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Exploring Empathy in Medical Narratives

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EXPLORING EMPATHY REGULATION IN MEDICAL NARRATIVES

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ABSTRACT

EXPLORING EMPATHY REGULATION IN MEDICAL NARRATIVES

By

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In response to the perceived dehumanizing methods of biomedicine, the humanist medical movement of the 1960's brought with it a demand for the return of empathy to clinical practice. With this demand, the interdisciplinary field known as the medical or health humanities sought to bring empathic and humanistic care through the arts and literature, with a focus on patient-provider communication. From this field came narrative medicine, a field that looks to facilitate patient-provider communication through the inclusion of patient narratives. However, even with all the support, the implementation of empathy into medicine proves to be a complicated endeavor. Empathy, a complex emotion that resists definition, can have adverse effects for both patient and provider when not applied and regulated correctly.

There are various strategies involving the regulation of empathy in medicine, including distancing, detachment, or emotional numbing. There is no one standard method, and what might work with one patient might not work for another, as with providers. To understand how these various methods and strategies work, I argue that an examination of provider narratives can provide insight into how empathy can be properly regulated in various situations. The narratives of health care providers contain themes, metaphors, and elements that convey accessible communication about the ways in which empathy can be regulated and the benefits of that proper regulation.

ACKNOWLEDGMENTS

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INTRODUCTION

*To my mind, empathy is in itself a healing agent. It is one of the most
potent aspects of therapy, because it releases, it confirms, it brings even
the most frightened client into the human race. If a person is understood,
he or she belongs.*
                    -Carl Rogers "Empathic: An Unappreciated Way of Being"

Since the rise of the humanist medical movement in the late 1960's, there has

been an overwhelming demand for the return of empathy to medicine. This demand

exists as a backlash against the biomedical model, which involves the blending of science

and medicine and, it is argued, results in an approach that is "not as humane as it could

be" (Danini 58). In response to the understanding that biomedicine favors an approach

that treats the disease rather than the patient, in recent years, the field known as the

medical or health humanities has sought to bring empathic and humanistic care through

the arts and literature, with a strong focus on patient-provider communication. With this

focus on communication, the field of narrative medicine was born out of a perceived need

to "teach doctors [and other care providers]" the "language" necessary to treat the patient

as well as the disease (Rudnytsky 24). This "language" would enable empathic, patient-

centered care and "honor the complexities of the self's relation to the body in which it

lives" (24). Through the inclusion of empathy, by way of patient narratives, providers

would theoretically be able to give a more complete form of care that incorporates the

patient into the method of healing and medicine.

However, the implementation of empathy into medicine carries with it various

complications. When not taken into consideration, these complications can result in

adverse effects for both patient and care provider: poor treatment for the patient and burnout for the care provider. Burnout, a serious condition that can lead to suicide, can arise when empathy and emotions are not properly regulated in clinical practice. Because emotions are "generally outside of people's control," empathy needs to be broken down into components to allow for its implementation into medicine (Halpern 670). Once defined in its components, empathy is believed to be to be more manageable in its implementation (that implementation known as "clinical empathy"); however, due to its complexity, the strategies of implementation and regulation of empathy can differ greatly depending on the provider and the patient being seen. This thesis explores how a study of the narratives of medical professionals has the potential to teach various strategies of clinical empathy and promote an understanding of the importance of empathy for both patients and care providers.

<div align="center">Biomedicine versus Humanistic Medicine</div>

The term "biomedicine" was coined during the interwar era and has become the "common shorthand" for the collaborative work of doctors and scientists (Lowy 117). The "turning point" for the "biomedicalization process," which "accelerated and intensified collaboration between biologists, clinicians, and industrialists," happened some time during World War II, and this collaboration was "exemplified" by the "wartime production of penicillin" (Lowy 117). Furthermore, the advancement of biomedicine was made possible by post-war funding for the sake of "medical research" and "extension of health insurance to large parts of the population" (Lowy 117).

In its science-centered view, biomedicine is perceived to be restricted to a calculating world of laboratories, knives, and prescription drugs, unconcerned with the humane treatment of patients. This perception was perpetuated by the "intertwining" of laboratory sciences and clinical practices, as well as the "rapid growth of the pharmaceutical industry" and the "large-scale production and testing of drugs" (Lowy 117). Kathryn Montgomery Hunter, a professor at Feinberg School of Medicine, argues that "despite its success, medicine's identification as a science has had adverse effects," mainly involving a "focus" narrowly confined to the "diagnosis of disease rather than attend[ing] to the care of the person who is ill" (Hunter xix). Additionally, Rita Charon, professor of narrative medicine at Columbia University, makes the claim that "the price for a technologically sophisticated medicine" is one that renders the "singular and meaningful situations" of patients to be ignored by a healthcare "consumed with the scientific elements" (Charon 6, 9).

Due to its science-minded focus and influence on healthcare, biomedicine's perceived inhumane practices have prompted a call for a more human-centered approach, an approach involving the application of empathy; this approach came to be known as humanistic medicine. [M]edicine is not a branch of science and it will never be" wrote George Sarton, an American chemist and historian: "[i]f medicine is a science, then it is a social science" (Sarton 319). The concern surfaced over biomedicine's focus and "interest" on "laboratories" rather than "doctors' surgeries and hospital wards" (Lowy 122). Such an observation may seem unnecessarily generalizing, seeing as the practice of medicine requires the application of the "scientific method," but it is argued that it would be wrong to think of medicine as an "applied science" because medicine "has an

autonomous position" within "our system of learning" (Sarton 319). According to the proponents of humanistic medicine, the dedicated and focused intertwining of the laboratory and the clinic is rather unfitting. A humanistic approach "considers people in their intrapersonal, interpersonal, cultural, political, economic, mythic, spiritual and historical contexts" ("Guidelines for Humanistic Practice"). Therefore, it is argued that medicine not be "reduced to a science" as it should remain human-centered (Lowy 121).

 The humanistic approach to medicine is concerned with how empathy and a patient-centered focus can be brought into healthcare. It is opposed to a biomedical approach, which fosters the "detached concern"[1] in which emotions are "neutralized" to the point of a healthcare professional "feeling nothing" (Halpern 670).   Juliette Ferry-Danini, in her essay "A New Path for Humanistic Medicine," examines "humanistic" as a "polysemous" word. She observes that either the word can refer to a "philosophy that centers on humans, their dignity, values, and freedom" or it can refer to "something closer to humanitarian or humane," thereby "designating a concern for human welfare and compassion" (Danini 64). Both definitions represent what some feel is lacking in a healthcare system dominated by biomedicine. To answer the question "What will humanize medicine?" Danini draws from several authors to examine the three imperatives of a humanistic approach to healthcare.[2] The first imperative establishes the "importance" of the "emotions of both patients and physicians" in the "role of medicine and its practice" (Danini 64). The second imperative reinforces the first in insisting,

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[1] The method of "detached concern" is believed to have been pioneered, over a century ago, by the Canadian Physician Sir William Osler (1849-1919).
[2] Rita Charon, Havi Carel, James Marcum, Miriam Solomon, Jodi Halpern, and Daniel Sulmasy.

"patients should not be reduced to their biological bodies but regarded as physical and psychological beings" (Danini 64). Lastly, the third imperative observes that medicine be "defined" as a "fundamentally intersubjective practice," bringing a focus to the patient-care provider interaction rather than advocating for an approach that encourages detachment and dehumanization (Danini 65). Relying on the establishment of the above mentioned imperatives, humanistic medicine advocates for a tone of "mutual respect," "empathy," and "compassion" between patient and healthcare provider, giving the approach a "single framework" with which to "understand medicine: the patient-[healthcare provider]" interaction and relationship (Danini 65, 66).

Narrative Medicine

As stated earlier, the demand for a more humane and altruistic approach to medicine arose in the late 1960's; it was the psychologist Carl Rogers who stood as one of the first major voices to advocate the importance of empathy in healthcare. Although his writings pertained specifically to the practice of clinical psychotherapy, the way he framed the relationship of patient and professional can easily be transferred to other healthcare situations. He observed, "empathy is clearly related to positive outcome" (Rogers 8). Additionally, he reasoned that, as an "active process," empathy involved "reaching out to receive [a patient's] communication and meaning" and thereby "translating" the patient's narrative into "experienced meaning" (Rogers 4). This "experienced meaning" is the "full, present, and changing awareness of another," "translated" from the psychologist's "active process of reaching out to receive the communication" that could convey those experienced meanings and it is what gives

valuable insight to the healthcare professional and is the mutually beneficial goal of being present and listening to a patient (Barrett-Lennard). James Marcum, professor of psychology at Baylor University, echoes Rogers' concern for the "experienced meaning" of the patient, further providing evidence of the need for humanistic medicine:

> In contrast to the objective facts and to their logical analysis associated with objective, biomedical reasoning, the humanistic or humane models incorporate the patient's narrative of the illness experience into medical practice that uses subjective and personal reasoning. (Marcum 116)

The importance of the patient's narrative about illness in the practice of medicine brings us to one of humanistic medicine's methods: narrative medicine.

Bertha Pappenheim, in describing her own psychoanalytical treatment as Anna O., coined the term "the talking cure,"[3] which refers to the practice of verbal therapy. The idea that telling one's story holds therapeutic potential is central to narrative medicine. The aim of narrative medicine is to bring the lived experiences of patients into medicine in order to provide healthcare professionals with a deeper understanding of illness. Therefore, narrative medicine would seek to bring an emphasis to the patient-provider interaction. Furthermore, Charon makes the claim that the inclusion of narrative medicine would result in "more humane, more ethical, and perhaps more effective care" (Charon vii). Narrative medicine is meant to establish the patient as a "physical and psychological being" rather than a petri dish. Thus, the aim of narrative medicine is to help educate the provider on how to be more empathic and provide more humane care.

For medical students, the usefulness of narrative is presented in two ultimate goals: (1) *attention*: strengthen the attention of the care provider as to access the patient's

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[3] Sigmund Freud *Five Lectures on Psycho-Analysis.* Penguin. 1995.

situation more accurately and to permit the use of empathy; (2) *affiliation*: provide the patient with the care provider's knowledge, skills, power, and caring, shared through an effective patient-professional affiliation (Charon). Proponents of narrative medicine believe that taking time to listen to patients' experiences of illness, in combination with the technological advances of biomedicine, results in a more effective form of healthcare can be achieved.

In Arthur Kleinman's *The Illness Narratives* (1988), the possibility of a more complete healthcare, through the collaboration of biomedicine and humanistic medicine, is explored through the author's personal experiences with patients. When thinking back to an elderly patient who had contracted syphilis from a serviceman during World War I, Kleinman realized that there existed "two sets of long-term problems" facing this patient (Kleinman xii). The first problem consisted of the "insidious medical complications" present from the syphilis; the second was the "life trajectory that her illness had marked and inexorably shaped," or how it had come to shape and define her as a human (Kleinman xii). What appeared striking for Kleinman was that his medical training had "systematically educated" him on how to treat the first problem but would lead him to "discount" or even "blind" him to the second (Kleinman xii). If one were to acknowledge the existence of these two problems, it should follow that something more is required in addition to the "systematically educated" means of biomedicine. He claims that to address the second problem would require the addition of narrative medicine to medical curricula, in order to address the "difference between the patient's experience of illness and the doctor's attention to disease" (Kleinman xii). For Kleinman, patient narratives, and how to listen to them, are what is missing from medical education.

The claim made by Charon, Kleinman, Marcum, and others is that through expressing empathy and listening to the narratives of patients, healthcare providers are able to address an important level of the healing process, one outside the biomedical realm of physical symptoms. Humanistic practices of empathy and narrative medicine have been implemented through the inter- and multi-disciplinary scholarly field known as the medical or health humanities. The University of Oxford defines the medical humanities as a "richly diverse field of scholarship" that "draws on disciplines in the humanities, social sciences, and the arts." For the purpose of "providing insights into one of the most basic and universal of human concerns, these disciplines can inform the science and practice of medicine" (Oxford). The medical humanities enable inter and multidisciplinary research (cultural and literary) to take place between medicine and the social sciences for the purpose of furthering medical education and practice. The literature and philosophy of medical humanities could be seen as being comprised of the soft sciences to the hard sciences and thereby serving as a complement to biomedicine's world of medications and surgical instruments. The late K. Danner Clouser, in a 1980 keynote speech at a health education conference, spoke of the void in medical training that the humanities can fill:

> What's missing in a vocational training? […] It leaves out everything that makes us uniquely human. Where do we train for understanding, suffering, and joy? Where do we gain ideas and models – for motivations, for patterning out lives, for fashioning out goals, emotions, attitudes, and character? […] Where do we gain perspective on our own life, on others', and the relationships between them? These things don't just happen, however much we like to believe they do. (Clouser)

For Clouser, the humanities can supply what is missing from medical education. His

claim relies on the premise that, by way of its integration into education, the humanities

can teach empathy and other humanistic values.

<u>Empathy Regulation</u>

Since the rise of the medical humanities, training models have been developed

with the intent to bring empathy to the core of medicine. Models such as mandatory

courses, goal setting, and lecture have been among the most common methods of

education (Aggarwal). Empathy training and assessment have become not only part of

early medical training, but also a consistent topic within medical literature, and is the

subject of numerous medical conferences. Notably, the introduction of empathy training

raises some complicated issues, mainly pertaining to the definition of empathy and how

exactly should it be implemented.[4]

Subject to "complex, multifaceted definitions", there is "considerable

disagreement" over how empathy should be defined (Shapiro 276). If empathy is

difficult to define, how can it be properly implemented into medicine? It is not that

empathy lacks a definition. On the contrary, it has many definitions that seek to bring

precise language to something intuitive and yet difficult to define. For the purpose of this

research, I will refer to the vernacular definition of empathy as the experience of

understanding and relating to another's state of emotion from his or her perspective.

Interestingly enough, such an ability to "adopt the perspective of another" is thought to

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[4] For more on the complex nature of empathy, especially as it pertains to medicine, see
"What's it all about, empathy?" from *Nurse Education Today*, Volume 17, Issue 2, April
1997, pages 106-110.

be "unique" to humans (Decety 338). Because empathy is associated with and promotes

prosocial behaviors (voluntary actions intended to help or benefit another),[5] it is thought

to be a desired trait for those working in medicine. However, when systematically

applied within the practice of medicine, where precise language matters, empathy must

be broken down into components to better understand and examine its process.

Janice M. Morse, a professor of nursing at the University of Utah, has made the

claim that there are four components of empathy.[6] Drawing from clinical psychology,

she defines these components as *behavioral*, *cognitive*, *emotive*, and *moral*. The

behavioral component is the communicative response with which one conveys

understanding of another's perspective. This component involves the ability for a care

provider to demonstrate effectively to patients that their suffering is understood.

Empathic understanding is conveyed through body language, tone of voice, choice of

words, and so on. An understanding is communicated without having to be spelled out.

An example of behavioral empathy would be a doctor "touching a shoulder or knee" of a

distressed patient (Shapiro 278). Additionally, the "manifestations" of this component of

empathy are capable of being "observed and evaluated" through scientific means (Morse

275).

The *emotive* component of empathy is the ability to subjectively experience and

share in another's psychological state, emotions, or intrinsic feelings. Because of the

nature of emotional distress, this component is seen as the contagious aspect of empathy,

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[5] Batson and Shaw, 1991; Davis, 1983; Penner, et al, 2005; Decety and Hodges, 2006;
Decety and Lamm, 2006; Wiseman, 2007.
[6] From the *Journal of Nursing Scholarship* vol. 24, no. 4, Winter 1992. Although this
analysis is nearly 17 years old, its findings are still relevant as scholars within the field of
medicine are still citing it within the on-going debate of empathy.

or an "emotional contagion." An emotional contagion is "a person's emotional response while observing another person's actual or anticipated condition" (Gladstein 471). An example would be if one were to observe someone's grief, embarrassment, or joy and then feel that very same emotion. It is natural to mirror and experience the emotions of another. Such mirroring can make empathy dangerous in a clinical setting; however, when exposed to the suffering of others on a daily basis, without the skill to distance oneself, compassion fatigue becomes a serious concern (Hunt 8). In recognizing this emotional response, a provider is "motivated" to either "engage in cognitive and behavioral empathy" or to take the alternative and "distance him- or herself from the distress of another" (Morse 275).

The *moral* component of empathy is the "internal, altruistic force that motivates the practice of empathy." The inclusion of this component can be rather subjective and debatable as this aspect of empathy has not been "clearly delineated or defined" as its own "separate component" from the others (Morse 273). It is possible to attribute this to the already subjective nature of empathy and the debate as to whether or not there is a relationship between empathy and morality.[7] The link between empathy and morality is a complicated one as "empathy is not always a direct avenue to moral behavior" considering that empathy can "introduce partiality" (Decety 337). The moral component is "rooted in the philosophical belief" that we as a species "share common needs," "experience the same human condition," and are all "interconnected and interrelated" (Morse 274). Piaget believed that infants were born with the "raw materials" of

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[7] See Jean Decety and Jason Cowell's "The complex relationship between morality and empathy," *Trends in Cognitive Sciences*, July 2014, Vol. 18, No. 7.

"sympathetic tendencies" and "affective reactions" that later developed into moral behavior (Gradstein 475). Therefore, this component of empathy could be seen as the reason many decide to go into the field of medicine as a form of altruistic motivation, it is that "natural willingness" to "help other people who are distressed or who need assistance" (Morse 274-275.

The *cognitive* component of empathy is the intellectual ability to identify and understand another person's feelings and perspective intellectually. This component is also identified as "clinical empathy" (which will be explored later in this introduction) as it is a process of identification as to "whose emotions belong to whom during empathic engagement" (Hunt 9). It is a "teachable" skill that is "built on natural abilities" (Morse 274). Some emotional distance from patient suffering is required for this component but that distance must come from the ability to "comprehend, reason, analyze, and think critically" about the patient or medical scenario (Morse 275). The successful use of the cognitive component is "distinguished" by way of its use of "subjective" and "experiential input" for clinical interactions (Halpern 671). The objective of this component is in being able to create and establish that safe distance, thereby making compassion fatigue and burnout become less of a concern.

The purpose of emotional regulation is that it serves as a means to "free up cognitive resources" and allow healthcare professionals "to do their jobs better" (Carey).[8] To be more specific, a "well-developed ability" to "self-regulate emotions" will "reduce the risks of burnout" for healthcare professionals (Hunt 19). Empathy in medicine can be

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[8] For further detail on the study, see Jean Decety's review "The Neurodevelopment of Empathy in Humans," *Dev Neuroscience*, 2010, 32:257-267.

seen as a fine line: too much and a provider risks becoming overwhelmed and drained, not enough and the act of caring for patients becomes mechanical and loses all meaning. Both scenarios can result in burnout or compassion fatigue. Burnout is a serious issue for those who work in medicine as it can cause depression and can even result in suicide. The American Foundation for Suicide Prevention reports that about 23% of interns had suicidal thoughts and an estimated 300-400 physicians die, per year, from suicide in the U.S. (AFSP). It is not just the ability to "do" one's job "better" and "free up cognitive resources," but by regulating emotional responses, providers can avoid the serious risks of depression and suicide.

Psychologist Herbert Freudenberger originally coined the term "burnout" in the early 1970's to describe the "consequences of severe stress" resulting from "high ideals in 'helping' professions," specifically in the field of medicine (Cologne). Since then, the symptoms of burnout have increased in range as more symptoms are recognized, making the symptoms difficult to distinguish from those of anxiety, depression, and secondary traumatic stress, thereby making burnout more complex and more difficult to pin down with an exact definition. Although there is a wide range of symptoms, three main symptoms have largely been agreed upon: (1) *exhaustion*: an emotional fatigue characterized by inability to cope and lack of energy; (2) *alienation*: a feeling of increasing cynicism and frustration towards work and colleagues, characterized by emotional distancing and numbness; and (3) *reduced performance*: an overall negative attitude about work, characterized by an inability to concentrate, a listlessness, and a lack of innovation (PubMed Health). Often times, in literature about burnout within medicine, the symptoms of emotional exhaustion or "compassion fatigue" will mingle with those of

burnout. Compassion fatigue is the result of becoming "emotionally drained" by way of

"caring too much" and becoming "adversely affected by our efforts" (Figley 7). Much

like with burnout, it can be a consequence of being "emotionally vulnerable" (Figley 7).

As stated earlier, burnout and compassion fatigue are a serious concern for healthcare

professionals due to the high-stress environments they work in; in order to avoid the risks

of these ailments, healthcare professionals need to regulate their emotions to avoid

leaving themselves vulnerable.

The process by which empathy is regulated is primarily referred to as "clinical

empathy." Clinical empathy involves "cognitive empathy," the application of "emotional

attunement to serve the cognitive goal of understanding the emotions of the patient"

(Lakhani). Clinical empathy involves some distancing or detachment; it is an "act of

correctly acknowledging the emotional state of another without experiencing that state

oneself" (Halpern 670). It is a "skill" that is "developed through practice using one's

natural empathic capacity" (Alligood). In other words, it does not just come naturally but

requires "practice," as providers seek to offer humanistic care while protecting

themselves from burnout and compassion fatigue.

Existing data from studies in psychology and medicine point to the overwhelming

benefits of properly regulated empathy, for both healthcare professional and patient. For

patients, these include shorter recovery times and healthier outcomes.[9] For healthcare

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[9] For more information on the quantitative details of how empathy affects patient health,
see Christine Thompson's "Uncovering the Patient Experieince: Empathy Mapping
Promotes Patient-Centered Care for Improved Heart Failure Patient Outcomes," *Journal
of Cardiac Failure*, volume 22, issue 8, August 2016, pages S87-S88. As well as Joanne
Olson's "Nurse-Expressed Empathy, Patient Outcomes, and Development of a Middle-
Range Theory," *Journal of Nursing Scholarship*, March 1997.

professionals, there is an added occupational understanding and a reduced risk of clinical burnout and compassion fatigue,[10] but this is only if empathy is being properly regulated. As Gerald Gladstein, a professor of education from the University of Rochester, points out, empathy "does not necessarily lead to helping behaviors" (Gladstein 477). Referring to "emotional or affective" empathy, or what Morse defines as the "emotive" component, he explains that this form of empathy can act as a "contagion" and "affect the observer," causing an "overreaction" and "empathic distress" that has the potential to "lead [the observer] away from helping" (477). He goes on to point out Roger's cautioning that "there must be an appropriate amount" of empathy and Stewart's argument that a "deliberate distancing must occur after emotional involvement" (477). I argue that empathy can be thought of as a medication, but unlike most medications, empathy affects both patient and provider in its dosage and side effects. However, there is no pharmacology for this medication; there is no recognized textbook that can provide guidance in its administration. It is something that must be experimented with and practiced on.

Currently, the clinical education in empathy, with its "plethora of words expended in support" of its training, "has not successfully translated into sustainable and effective attitudes and actions" in healthcare professionals (Shapiro 276). The demand for a return of empathy to medicine is a strong one, but how exactly empathy can fit safely and effectively into the clinic is still up for debate. Although the humanities are often touted

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[10] Patricia A. Hunt's (et al.) "Burnout and its Relationship to Empathy in Nursing: a review of the literature" and Jodi Halpern's "What is Clinical Empathy?" discuss how well-regulated emotions can lead to more meaningful and satisfying occupational lives within medicine.

as a solution for a lack of empathy in medicine, there is some debate over their ability to

foster empathy effectively. In her book *Literature and Medicine: A Claim for a*

Discipline (1984), Anne Hudson Jones voices her concern over the expectation that

studying the humanities will foster humanistic approaches and make one more humane.

She states that the "expectation" makes her "very uncomfortable" as such an "expectation

is a burden, not just for literature, but for all of the humanities," going on to point out that

although she, and many others, would "hope" that the humanities would make one more

humanistic, she has seen "too many examples of the contrary" in order to "believe in any

guarantee" (Jones 32).[11] It would seem as though either maybe something is missing

from empathy education or the training of such is far more complex than it is given

credit.[12]

     This, I would argue, is where the idea of narrative medicine comes in. If

narratives are the means by which the lived experiences of illness are conveyed, then it

should hold true that the narratives of healthcare professionals are the means by which

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[11] For a more contemporary take on the limits of empathy training, see Paul Bloom's book *Against Empathy: The Case For Rational Compassion (2018).* Bloom argues that for those healthcare providers who go through empathy training, the "negative affect was increased in response to both people in distress and even to people in everyday life situations" which suggests an unnecessary compounding in "distress" for both patient and provider, brought on by empathy training.

[12] It could be argued that the "practice of empathy" is complicated, and the degree of application of clinical empathy will greatly depend on the provider's occupation, personality, and history, or simply put "life experiences." Perhaps the reason for the lack of success is that there is no one correct method of empathy regulation for everyone. Such a hypothesis is not ungrounded, given what has been previously discussed in regards to definitional complexities pertaining to empathy, burnout, and the role of education in perspective taking. I would argue that the complexities exist on an individualistic basis, meaning that the method and degree by which empathy is regulated varies greatly from person to person and from occupation to occupation. In other words, it could be argued that clinical empathy, like medicine, should be viewed and examined as a process akin to "an art (as opposed to, and addition to, a science)" (Danini 61).

the regulation of empathy is conveyed. The documented experiences of doctors and nurses should provide insight into strategic degrees of emotional engagement and disengagement. Provider narratives could yield methods on empathy regulation and thus methods to avoid burnout. Furthermore, these self-reflective accounts are a form of medical narrative practice, as they provide validation and insight to the personal experiences of healthcare professionals by revealing the various dimensions of healing as expressed by Kleinman.

If the lived experiences of healthcare professionals are examined through Charon's goals for narrative medicine, *attention* and *affiliation*, then it should be possible for readers of these narratives to gain a situational awareness of the development and practice of emotional regulation. Because narratives can convey the varied emotions, experiences, and histories each professional brings with them, these personal histories have the potential to convey how the process of empathy is regulated and how stress and trauma are internalized. Therefore, it should be acknowledged that the narratives of healthcare providers convey the various methods in which each occupation and each individual works to regulate empathy in an attempt to stave off burnout. It is the purpose of this review to analyze the narratives of doctors and nurses in an attempt to understand and interpret various methods of clinical empathy and identify the practices by which empathy is regulated and burnout is avoided.

In order to examine the self-reflective modes and methods of empathy regulation, the contemporary accounts of doctors and nurses are presented here as works of medical narrative. The narratives are chosen for their deep level of self-reflection and for their range in strategies of empathy regulation. In order to use the most relevant concepts and

terms, these narratives are examined using commentary from scholars from the fields of humanistic psychology and medicine, psychoanalysis, and the medical humanities. Humanistic approaches to psychology and psychoanalysis best provide the framework from which to understand the components of empathy and their process as well as the effects and causes of burnout as they are described by the texts in my archive.

<center>Chapter Summary</center>

The narratives chosen for this project offer various strategies and methods evident in not only their self-reflective content, but also in their narrative form and framework. The first chapter explores narratives by doctors. Dr. Frank Huyler's prose poems, which detail life in the emergency room, and Dr. Danielle Ofri's reflective and analytic essays, about the emotional aspect of medicine as it applies to trainees and practicing physicians. Both works are examined in relation to the dehumanization of both patient and provider that can result from an expectation of complete empathic distancing. The distancing allows for objectification, which takes the place of the meaningful and humanistic encounters that are missing in the patient/provider relationship. How emotional expectations placed upon doctors can affect everyday interactions with patients is examined in the context of narrative and empathy regulation.

The second chapter explores narratives by nurses. Narratives from Kimberly Condon, Janice Hudson, and Laura DeVaney detail experiences from a range of positions from the emergency room, hospice, post-surgery, and emergency flight nursing. DeVaney's narrative is a self-reflective account detailing empathy regulation in a post-surgery cancer ward. Hudson provides the experiences of an emergency flight nurse, a

first responder on the front lines of medicine. Lastly, Condon an empathic ER nurse who

turns to hospice work, examines her own struggles with having to distance herself

emotionally from patients. This chapter's self-reflections on empathy regulation address

empathy as an emotional contagion, as noted by Gladstein. Autonomy and

hyperindividualism become subjects of concern in the process of these nurses building

their own immune system against the contagious effects of empathy.[13]

      Taken together, this study of these narratives will show that there are elements

and themes present that can provide useful information and insight into the complicated

process of empathy regulation. Furthermore, this study will show that it is narrative

writing that allows for the communication of strategies of the empathic process and the

complexities that surround it.

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[13] Though it is true that nursing is dominated by women and it could be argued that women are expected to be more empathic, an analysis on such is outside the scope of my research. For more on this subject, see Leonardo Christov-Moore's "Empathy: Gender effects in brain and behavior," Neuroscience & *Biobehavioral Reviews*, Vol. 46, Part 4, Pages 604-627, 2014.

The old-timers used to tell me that the longer you work this job the longer your stethoscope. I wore the longest on the market, and still I could hear, under the pulse, the heart's fortune-telling wail. Through the bubbling air in the fluid-choked chest, a terrible silence. No instrument can block that.
—Joseph Connelly, *Bringing Out the Dead*, pg. 87

In the winter of 2017, the bizarre details of a trial involving a surgeon who carved his initials into the transplanted livers of his patients appeared all over news outlets. The surgeon, Dr. Simon Bramhall, "admitted two counts of assault by beating" in relation to using an "argon beam" to burn "SB" onto the livers of two patients (Perraudin). It was determined by the court that both incidents required "skill and concentration" and were performed "in the presence of colleagues" (Perraudin). This alarming case prompted many to recount a similar incident in 2000 when a Dr. Allan Zarkin carved the initials "AZ" into the abdomen of his patient, after performing a Caesarean section, leaving the patient feeling, in her own words, like a "branded animal" (Wongjan). Neither of the doctors personally offered any public explanation for their actions, leaving their motives to speculation. However, in an opinion article written in *The Guardian*, Dr. Henry Marsh, a surgeon and published author, attempts to offer an explanation involving emotional distancing and empathy.

In an effort to shed light on the reasoning behind such disturbing actions, Marsh claims that he and other doctors "walk a tightrope between compassion and detachment" (Marsh). The metaphor of the "tightrope" illustrates the alleged danger of doctors becoming "disinhibited" in their work (Marsh). Additionally, the metaphor offers some insight into the level of danger and skill that is involved when treading carefully around

empathy and emotion in medicine; one misstep could be costly. Marsh's notion of doctors walking a tightrope alludes to how cognitive empathy works by comparing the regulation of one's emotional responses to the skillful and difficult act of balancing on a rope suspended dangerously high in the air. However, Marsh goes on to advocate for a completely "detached" approach, free from empathy, when dealing with patients, making the claim that "empathy is the last thing [doctors] want" (Marsh). His claim is that when a doctor falls off the "tightrope," he or she runs the risk of "disinhibited" actions, such as leaving a "brand" on a patient, an action that Marsh calls "silly," but not "criminal." It could be that Marsh does not subscribe to the idea that empathy can be regulated as he advocates for a mode of disconnection by being "as emotionally detached as possible from the patient" (Marsh). Such an emphasis on emotional distancing is an approach known as "detached concern."

Canadian physician Sir William Osler, often described as the "father of modern medicine," helped to cultivate the detached approaches that later become associated with biomedicine (Ofri 3). In a speech to the graduating medical students of the University of Pennsylvania, in 1889, Osler underscored the dangers of sensitivity and empathy, stating, "A certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of a calm judgment" (Ofri 4). In place of empathy, he argued for a "neutralizing" of emotions to the point that physicians "felt nothing in response to suffering," thereby allowing them to "study" and "see into" the "inner life" of the patient (Halpern 670). Theoretically, by stripping humanistic traits and elements from the practice of medicine, a physician would separate himself or herself from the patient for the purpose of efficient observation. For Marsh, "experiencing emotion" is

"unimportant" in "understanding what a patient is feeling" (Halpern 670). The model of

detached concern "presupposes that knowing how a patient feels is no different from

knowing that the patient is in a certain emotional state" (Halpern 670). Such a position

assumes that the inclusion of any such emotional process to be a "threat to objectivity"

and that "experiencing emotion" is deemed to be "unimportant for understanding" the

patient (Halpern 670, 671).

The emotionless, disconnected doctor may sound like a very familiar stereotype,

one possibly found in novels, film, or other mediums of entertainment. Such a trope

could best be referred to as the "television doctor"[14]. Characteristically, the television

doctor will remain "detached from patients" and from empathy, while being praised as a

paragon of "technological and diagnostic acumen." Entertainment media presents these

cold and calculating doctors as heroes and heroines of western medicine (Ofri 4).

Characters like Dr. Cox from *Scrubs* (2001-2010), Dr. House of *House* (2004-2012), and

Dr. Casey of *Ben Casey* (1961-1966) are all lauded for their biting and bitter sarcasm and

clean-cut efficiency and exist as fictional characters of detached concern's success

applied to everyday clinical scenarios. The television doctor is detached concern

manifest into a persona, or extrinsic self. Dr. Danielle Ofri, a practicing physician and

professor of medicine at New York University of Medicine, in her reflective, personal

essays, offers insight into the mentality that encourages many doctors to adopt this

persona that has become a popular staple in media:

> Nobody was interested in hearing from doctors who were having doubts, who
> were overwhelmed, who were unraveling. "Suck it up" was the modus operandi.

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14   The distant "television doctor" persona can be seen as an extrinsic self, or constructed
personality, that has two purposes in this case: to keep the patient's emotions at a distance and to
keep the physician distant from his or her own emotions.

> Real doctors were supposed to be immune to this sticky side of medicine or, at the very least, able to handle it discreetly, covertly, alone. (Ofri 167)

The use of the label "real doctors" is alarming as it shows that doctors who have not neutralized their emotions are not even to be considered part of the clinical practice simply based on their inability to neutralize their emotions. Additionally, the demand for stoicism goes further to include the doctor's own fears and doubts, locking down not only the processing of patients' concerns, but also the doctor's. Doctors are meant to be some form of omnipotent being, one "immune" to the emotional responses of patients and all-knowing in their observations. Has society been under the model of biomedicine and scientific management for so long that the normalization of detached concern as made the idea of a doctor with emotions that unsettling? The detached television doctor paints an attractive but unrealistic ideal for physicians who would attempt to avoid emotions and empathy and for those who would expect it. The typical fictional doctors display an unwavering control over their emotions that allows for the control of both the patient's anatomy and their own psychological state. The current health care system seems to have established this "modus operandi" of efficient, stoic, detachment that runs so deep that doctors are expected to be emotionally numb in nearly all aspects of their life. There are dangers in certain approaches to medicine, and an all-or-nothing approach to empathy is one of them:

> [L]ack of investment can lead to rote medical care—impersonal at best, shoddy at worst. At the other end of the spectrum is the doctor who is inundated with grief and can't function because of the overwhelming sorrow. Burnout is a significant risk in both of these cases, and that erodes the quality of medical care. (Ofri 121)

Here Ofri provides further insight into why proper empathy regulation is important. Her reflection could be applied to the "tightrope" analogy referred to earlier; however, Ofri

offers a more accessible and defined representation of empathy and detachment in

medicine. The doctor who stands a better chance against burnout and disinhibited actions

places him or herself between the two extremes, finding a personal balance and

regulating his or her emotional process, the use of clinical empathy. However, even for

those doctors who have found a balance with empathy and wish to be more engaged with

their patients, the current system of efficiency seems to place restrictions on a doctor's

involvement with a patient's needs:

> Sure, it's wonderful to have an in-depth conversation with a patient, to do a more
> thorough physical exam, to patiently explain the disease process to a family
> member, to read up on a rare disorder, to attend that lecture on communication
> skills, to visit a patient a third time in the day, to make those extra phone calls to
> unravel a patient's medical history, to let a patient ramble on without
> interruption—but none of these things will get the work done. The scut list will
> still be there. (Ofri 34-35)

Recognizing the need for workload balance, Ofri points out the multitude of beneficial

steps that would, on one hand, greatly improve health care, but on the other hand, serve to

overload an already overwhelmed doctor: As expressed by Ofri, in giving a patient ideal

care, there is the potential for a great deal of extra work and it is only natural that many

doctors can develop burnout from the pressure of the overwhelming expectations of both

the system and patients.

 However, the alternative could reasonably be seen as dehumanizing, as it makes

the patient out to be an object rather than a human. Moreover, the method seems to

attempt to make doctors out to be analytical machines rather than everyday people with

emotions. Referring back to Marsh's analogy of the tightrope, given an understanding of

detached concern and the numbing of empathy, could it not be said that it is the

application of disconnection rather than the application of empathy that causes doctors to

"treat patients as objects" and thereby enabling doctors to sign or "brand" their work, effectively dehumanizing the practice of medicine? True, empathy, when unregulated, can prove to be dangerous for providers, but it is doubtful that it is compassion and an empathic connection that enables the disconnect necessary to view patients as objects or animals. Would it not be more reasonable to argue that while doctors do walk a tightrope, it is not only unchecked empathy that causes them to slip off but also the complete lack thereof?

What is to be observed in these examples of dehumanization and branding is that the desire to leave one's mark seems to exist as a form of "objectification" which could be seen as a consequence brought on by detached concern's "neutralizing" of emotions. It could be argued that if "calm judgment" and "efficiency" are the focus for these modes of dehumanizing detachment, then the patient is in danger of becoming an object or product to be signed off on and the doctor a machine working far removed from human emotion. Sociologist, philosopher, and critic, Georg Simmel[15] defines "objectification" as the "means by which people take possession of the world around them in words, works, organizations, and tradition" (Timmermans 22). Additionally, the sociologists Peter Berger and Thomas Luckmann[16] see it as a "dialectic process" by which one "internalizes meaning" and "expresses" that meaning in ways "accessible to others," making objectification an "ability to recognize human products as elements of a common world" (Timmermans 22). This process becomes a form of communication between the

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[15] Simmel, Georg. *The Philosophy of Money*. Routledge. 1990.
[16] Berger, Peter L., Thomas Luckmann. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Anchor Book. 1966.

"common world" and the individual as the individual attempts to make accessible and "express" meaning. The surgeon's initials can be seen as a form of this communication. The television doctor as an extrinsic self may not be as obvious a form of objectification as branding a liver, but it can still exist as a means by which doctors can attempt to "take possession of the world around them" through a "tradition." Taking the practice of medicine and associating it with the tropes popular in media would allow for an "expression of meaning" to the "common world" in a way that is highly "accessible to others." Even if the adoption of the television doctor persona does not present itself as an overly alarming action, like that of branding a patient, it still brings with it all the associated issues detached concern presents. Through the use of this persona, doctors will be expected to condition themselves as machines of efficiency and view patients as product or objects of study.

If one is to accept that doctors are to condition themselves devoid of emotion and operate as efficient machines, then it might follow that such conditions would render the practice of medicine removed and distant from the humanistic act it should be. It would seem that the dehumanizing aspect of objectification takes place when the provider's work and ability to empathize with patients is "neutralized," which then, in turn, results in a neutralizing of the patient's "agency" by observing them as something less-than-human, resulting in an "erasure of authenticity, an alienation of identities and a silencing or even displacement of the self and the social world" (Timmermans 22). Such is the case for those patients who, when signed with their doctor's initials, felt like a "branded animal." In the case of the two surgeons, a paradox happens: by signing their work, an effort is made to connect their labor and identities, to the world around them, as

desperately human; however, in that dehumanizing act of burning their initials into the patient, the patients' autonomy is damaged, making them less than human. The act of branding their patients could be examined in two ways: the provider's initials could be an attempt to "make meaning" of their work or it could be an attempt to "take possession" of the clinical act they are engaged in. Either way, due to the objectification suffered by the patients, they suffer dehumanization twice over: once as a result of the initial application of detached concern and a second time to satisfy a need to bring a humanistic element when there was none.

The issue of objectifying and marking patients in the medical context can be compared to what goes on in factories and on assembly lines where workers are encouraged to operate as machines. Consider the narrative experiences of a steel mill laborer from Studs Terkel's famous book *Working: People Talk About What They Do All Day and How They Feel About What They Do* (1979). The narrative of a steel mill laborer named Mike LeFevre begins the collection; his experiences stress the importance of worker-recognition in conditions that foster disconnect, dehumanization, and efficiency. "It's hard to take pride in a bridge you're never gonna cross" or "in a door you're never gonna open" for, as LeFevre points out, if "[y]ou're mass-producing things and you never see the end result of it" then there is no "pride" to be had in one's work (Terkel xxxi). LeFevre sees his tasks as anonymous and, as such, finds it difficult to "internalize meaning" in his work. His readily accessible response to the disconnect from his work is to have some form of recognition established, whether that be a plaque, a memorial, or a signature. Such a "readily accessible" method to show that a human, someone with a name and "agency," was behind this product and that someone gave

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laborious time and effort into its construction. He confesses to occasionally putting a "dent" in his work, making the product "unique" so that, among the routinized element of mass-production, he knows that one part stands out as his own, having left his "brand" on it (Terkel xxxviii). Denting one of the parts he is working on is his form of meaning-making, a form of which is much less severe than carving initials into a patient, but perhaps carries with it the same reasoning. In order to show pride and give his work a "recognizable human element," he creates a product that is uniquely flawed and thus apart from the rest. One could also view the "dent" as anonymous signature, one that won't lead his foreman directly to him. He likens his "disinhibited" compulsion of his to the existential crisis in Ernest Hemingway's *For Whom the Bell Tolls* (1940), in which the protagonist looks to an unborn child as the only hope for his continued existence; "if you die, I die" he says to the pregnant mother (Terkel xxxviii). Because of the dehumanization and disconnect to which he is subjected, without that verifying "brand" his work and, by extension, his existence become purposeless.

The dehumanizing distancing laborers like LeFevre feel between themselves and their work is the result of an industrial method based on the "principles of scientific management," which, it would seem, has also left its mark on medicine. Since its publication in 1911, Frederick Taylor's *Principles of Scientific Management* has had a significant influence on Western industries. Conceived as a process by which managers could increase the productivity of their laborers through worker conditioning and micromanagement, the principles— formulated by Taylor, an American mechanical engineer— have since spread outside the repetitive assembly lines of factories into nearly all sectors of the Western workplace. Through the implementation of "systematic

observation" for the "standardization" of human behavior, Taylor boasted of his ability to improve the common worker's efficiency and product output (Ewen 80). His methods required that the ideal worker be viewed and treated as a "pliable instrument" and "automaton" performing functions with "routinized elements" (Ewen 80). The worker would be effectively dehumanized and reduced to the status of a machine. Taylor's mental conditioning of a worker involved the "systematic stripping" of traits and aspects that had previously relied on the "judgment and discretion" of skilled workers, removing the capacity for reason and discretion and making their actions automative (Ewen 80).

This system of management reduces, or rather "simplifies," the worker's tasks into a string of automated procedures, thus severing the connection between a "worker's mind and hand" (Ewen 80). The worker, stripped of humanity, becomes the ideal "instrument" of efficiency. Within the push for that "highest state of efficiency," the worker and the product and its production become meaningless outside of the desired run-time quantity, or how much product can be pushed through in a shift (Ewen 81). For the sake of productivity, workers are pushed to their very limits and are overworked,[17] creating work environments that foster conditions for burnout.

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[17] Being overworked is a serious concern for many doctors. Many feel as though they are "burning a candle at both ends." It was found in a survey that 81% of U.S. doctors feel as though they work at either full capacity or are overworked (PMDS). The survey was conducted by a nonprofit organization, "aimed at advancing the work of practice physicians," to examine the results of being overworked, including the alarming and "steady rise" in "emotional exhaustion" and "detachment from patients," contrasted by the "plummeting levels" of "self-accomplishment" doctors experience (PMDS). Through the influence of detached concern, compounded by overwork, there is a disconnect between doctor and patient. As a result of this disconnect, many doctors run the risk of "treat[ing] patients more like objects rather than people" (PMDS).

When a system of labor strips away a worker's humanity, for the purpose of creating a purely objective and "pliable instrument," there seems to be a strong desire, or drive, on the part of the worker to "take possession" and create meaning in their labor. In the cases previously mentioned, the worker seeks to make the product of their labor "recognizably human" in a backlash against the "erasure of authenticity" and "alienation" brought on by the principles of biomedicine and scientific management. As highly unethical as it is for a doctor to engage in the disinhibited act of burning his or her initials into a patient, this act seems to be a mirroring of LeFevre's need to "stand out" and show that a human, imperfect and real, was behind the work.

Dr. Frank Huyler's collection of autobiographical prose poems, *The Blood of Strangers* (1999), addresses this need among physicians in rich detail. Huyler's collection offers unapologetic accounts of struggles with empathy within clinical practice, as well as the erosion of meaning and humanity in medicine. In the ER, some patients come in requiring a substantial amount of care before they are sent home or to another area of the hospital. Providers need to act quickly and do a great deal within a small window of time. A patient may come in unconscious and in need of life-saving treatment but later leave without ever having known the team that saved him or her. Or, worse, an abusive patient may take advantage of the ER staff's care, trivializing it. In such an environment, doctors need to make some meaning of their work. This is where narrative comes in. As to be observed in the examples to come, narrative has the potential to serve as a vessel for meaning-making. Through the act of narrative writing, doctors have the ability to construct meaning from the everyday clinical interactions and

satisfying the need to connect one's labor to the common world in a way that is accessible to others.

In a chapter titled "Needle," Huyler conveys the discussed desire to objectify and to take ownership of his work. Whereas the two surgeons discussed at the beginning of this chapter took this desire to the extreme by signing their patients (thus transforming them into "products"), Huyler offers a much less drastic means of satisfying the desire to "take possession" and "make meaning." The chapter details an event in which a patient, involved in a motor vehicular accident, is brought in from the trauma room. He is heavily sedated and his blood pressure is dropping. An x-ray of his chest confirms tension pneumothorax, a build-up of air in the chest cavity, caused by a punctured lung. This means the patient could die within minutes if swift action is not taken. Huyler provides a very telling description of himself running to grab a needle in order to release the air from the patient's chest cavity:

> I found myself sprinting down the hallway to the ER for a needle and syringe, fumbling in a drawer, turning, rushing back as patients and nurses stared at me. I felt like an actor in a melodrama, cutting around people with a needle in hand, with me white coat trailing behind me like a cape. (Huyler 50)

It is important to note that in nearly every aspect, all eyes are on him. His narrative expresses that what he is doing is a heroic act of great importance, one worthy of notice and deserving of an audience. With his audience, his work does not run the risk of becoming anonymous. He is "cutting around" people, implying deliberate movements of precision as he returns with the life-saving tool— the MacGuffin. His coat is symbolic of a hero's costume, as a "cape" that "trails behind." In this moment, he is an actor playing the hero role in the over-dramatized scenes that take place on *E.R.* (1994-2009) or

Chicago Hope (1994-2000), the kind of glorifying scenes that bring envy and admiration to doctors and recognition to their actions.

Returning, he plunges the needle into the patient's chest. The air escapes, letting out a hiss and "bubbles of bloody froth" (50). After the air has been released and the patient's blood pressure and heart rate stabilize, he reflects: "I realized that I had saved him, that he was alive because of me" (50). This moment brings with it a profound sense of accomplishment and pride that can only come with saving another person's life. To own his accomplishment, to take possession of this achievement and distinguish it, he "savors" the very existence of the patient's well-being: "I knew that he would leave whole, and I sat there in the dark for a while, watching the red and blue lights of the monitor, savoring him, taking something for myself" (51). Here Huyler is able to take ownership of his work in a way, I would argue, that does not dehumanize the patient or disturb his agency. Knowing that this patient may wake up and go on to never know who saved his life, Huyler is there to appreciate the now calm and peaceful space this patient inhabits.

A doctor's need to create and internalize meaning in his or her work is also evident in a chapter titled "A Difference of Opinion," which describes a situation in which a doctor is unable to spend those few moments to "savor" a job well done. Here, an attending physician "consider[s] withdrawing support altogether" from a young man suffering from "pneumonia sepsis" (75). Because the patient is a "young man," Huyler reasons in favor of an "aggressive treatment" to keep him alive (76). The treatment to keep the patient alive and recovering lasts for over a week and serves to "unfailingly rob [Huyler] of sleep" to the point that he had "come to dread [the patient]" (76). The

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amount and intensity of care that the patient needs have led Huyler to "know him intimately" after having "examined him dozens of times, turn[ing] him over to look at his back, put[ing] his gloved finger in his mouth, in his rectum, into the interior of his chest cavity, and [he] had never once exchanged a single word with [the patient]" (76). One cannot help but notice the repetitious way in which Huyler explains his part in keeping this patient's condition stable. His language is plain, matter-of-fact in its routine tediousness, contrasting against what it might mean to know another human intimately. To know another on an intimate level is to know the fears and hopes that drive him or her; Huyler only knows this patient in his anatomy as it applies to his care, nothing more. Due to the patient's condition, he is prevented from even engaging in basic, verbal communication. This patient and provider dynamic could be seen as a metaphor for a doctor's inability to have meaningful communication with a patient due to the dehumanizing restraint that detached concern places on patients' agency. To drive this metaphor further, he describes the patient, in his state of "near-death," as just a "body" with only an "animal-self" left to it (76). By way of detached concern, this excerpt echoes the condition in which doctors are asked to view their patients. In order to avoid any threat to objectivity, doctors should not look to know their patients beyond what's Huyler's gloved finger has experienced. However, it was Huyler's use of empathy that led to this patient's survival as Huyler argued for his treatment based on the patient's young age and what life he had yet to experience.

Six months later, Huyler recognizes a man in a pulmonary clinic waiting room to be the patient. When approached, the patient could only look up from his newspaper, "suspiciously," and ask "Do I know you?" (77). These are the four words the chapter

ends on, adding weight and authority to the lack of recognition for Huyler's efforts. With everything Huyler gave to keep this patient alive, for all his efforts, the young man has no idea that this is the doctor who argued against him being taken off life support. In this moment, the doctor, like LaFavre's laborer, is unable to "internalize meaning" due to anonymity. However, all is not lost as Huyler is able to construct some recognition for his efforts in the writing of his narrative, more so in its publication. Though the patient may never appreciate how close he was to death, the narrative's audience may take the place as witness.

Dr. Huyler provides two instances within which he recalls his uncomfortable struggle to maintain that distant extrinsic self and balance his empathy while performing highly invasive procedures. In both instances, the patients are visibly distressed and there is a considerable effort on his part to locate that balance between being emotionally numb and being burdened by the emotions of empathy. In the first example, he is preparing to administer a pelvic exam; his shame is palpable as his language suggests that the procedure is not so much a medical exam but rather a depraved act:

> You are breezy, conversational. She's fifteen years old, and she's crying, and the nurse is holding her hand like a mother, but she's beautiful anyway, and you feel dark, ashamed, you do not like what you see in yourself. But then you're inside, you open the speculum, and it looks fine, and then you flick in the swabs and you're done. (Huyler 124)

To put the reader into his level of discomfort, his narrative frames the shame and guilt he feels in conducting this routine procedure. The narrative use of "you" brings the examination into an uncomfortably close proximity. The actions he is taking are now the reader's actions and they are being performed on a crying, young girl. He attempts to hide his emotion with an air of nonchalance but it appears as though he is doing it more

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for his own reassurance than hers; for, as he states, he sees something unwelcome within himself—what we can assume to be a feeling of sexual arousal or interest. He cannot express his empathy for the pain and emotional discomfort his patient is experiencing and relies on the presence of the motherly nurse to provide that needed source of empathy, that connection, he is unable to provide.

In another uncomfortable scene, that again involves the specter of sexual invasion, a patient, involved in a car collision, is possibly suffering from a ruptured spleen. The procedure, again, is an invasive one, as it requires an examination of the patient's prostate. Learning of this, the patient cries out for his wife and begs for an alternative, due to past traumas:

> "Don't put it in, don't put it in, don't do it. Mary! Mary!" I just nod to the techs, and they grab his legs and spread them apart. "I was abused as a child. I was raped. You don't understand." I suspected it, and I pause, but it doesn't matter if I understand. You're fifty years old and I think you have a ruptured spleen, and you're going to die unless we know. (Huyler 113)

Although a ruptured spleen is a life-and-death situation, Dr. Huyler does give pause in response to his patient's plea. He pauses on what this invasive procedure means for this patient in relation to his past trauma and his pause invites a world of speculation. One could read Huyler's hesitation as a question to himself: "Is there another way?" and "Can I spare this man any further mental trauma?" For that pause, one could claim that he empathizes with what this man must be going through, but ultimately, it is the patient's life on the line and the procedure must continue. Although this is a life-and-death situation, Huyler allows the patient's narrative to temporarily overtake his own. Huyler and the techs fall into the background and the patient's fearful dialogue takes center stage. Even Huyler's reasoning stays outside of the moment, appearing as an

afterthought as indicated by the lack of quotation marks. One could read this as Huyler giving the patient's narrative its place, even when the given situation would not allow it.

In both cases, detached concern was seemingly used to fulfill a purpose. In the case of the pelvic exam, it seemed to have helped hide palpable shame and in a life-or-death situation; it helped to create distance from the pleading cries of the patient. The distance and hindering of emotion was obviously not comfortable for Huyler, as evident in his narratives, and it would seem that through giving these patients their moment in his writing, he looks to give them the voice detached concern would not allow.

As long as the current system of healthcare stands, many doctors may feel the need to create or salvage meaning and recognition from their work. It is worth considering the possibility that narrative writing allows for a healthy and ethical option for the desire to take possession of and find meaning in the product of one's work while maintaining the humanity of one's patients. Each heroic or harrowing detail could be captured as it happened, accessible for recognition for a wide audience while honoring the narratives of patients when constrains will now allow a doctor to do so at the medical encounter. Doctor's narratives, like Huyler's, allow an audience to see the very real and human elements to medicine that are hidden under the numbing expectations and conditioning of Taylor's principles.

NURSES

*"Caring isn't always about holding someone's hand. At the end of the
day, I know I've done my job when my patient wants to let go of me."*
    –Laura DeVaney, *Becoming a Nurse*, pg. 53)

In her narrative, "Becoming a Nurse," Laura DeVaney describes the profession of

being a nurse as a balancing act in being able to "walk a fine line […] between saving

lives and pissing people off" (Gutkind 47). Much like Marsh's use of the "tightrope"

metaphor, balancing is also central to DeVaney's narrative. Her job is ultimately about

"saving lives," but in the process of saving lives, she cannot be as gentle as her patients

may prefer. Although a bit brash, her philosophy echoes one of the qualities Florence

Nightingale assigns to a good nurse, which is to "be kind and sympathetic, but never

emotional" (Seymer 352). As evident throughout DeVaney's narrative, this balance is a

compromise that exists within her moral obligation as a nurse, to be "gentle but

professional" and to "love no patient but care for them all" (Gutkind 47). Such a clinical

philosophy seems to exude discipline and regulation of emotions.   This is how DeVaney

indirectly defines clinical empathy.

To give further insight into her balancing act of emotional regulation, her

narrative details the unpleasant task of cleaning fresh tracheal stoma for a patient in a

post-surgery ward for cancer patients:

> [The patient's] face is brick red. His neck veins bulge as thick as rat tails
> when he coughs. I'm elbow deep in frothy mucus, suctioning his tracheal
> stoma, the permanent breathing hole in his neck. […] If his voice box
> hadn't been surgically removed, yesterday, a slew of profanities would
> escape him. Instead, he looks at me with eyes that teeter between *I hate
> you* and *Thank you*. (Gutkind 47)

It would appear that there is a level of confidence in DeVaney, a belief that she has her method of clinical empathy figured out. Her empathy is regulated, and her philosophy of "walking a fine line between saving lives and pissing people off" is mirrored in her patient's mixed response of "hate" and gratitude. She is caring for him, without the aid of love. Her actions exhibit the emotive, cognitive, and moral components of empathy, as she recognizes his discomfort and pain but makes the cognitive decision to maintain a professional distance and not share in his suffering. The moral component expresses an altruistic motivation tempered with willpower that results in a "conscious decision to "[…] distance oneself from the other's plight," thereby avoiding "empathic communication" (Morse 275). She recognizes the discomfort her patient is experiencing from the suction tube inside his newly acquired stoma, but for the sake of his health and recovery, she makes the conscious decision to dissociate herself from his all-too-visible pain. Through the cognitive component, one that involves the "intellectual ability to understand another's perspective and predict his or her thoughts," she is certain in her understanding of both his gratitude and his intense displeasure all without his verbal confirmation. She reads his physical posturing without feeling the need to resonate or mirror and participate in his contagious pain. To do so would be careless, from her point of view, and would jeopardize her ability to properly care for him and aid him in his recovery from surgery.

In order to show how an unregulated emotional response, provoked by empathy, creates a conflict with medical practice, DeVaney shares the experience of teaching her patient's wife how to suction the tracheal stoma. The wife, lacking the cognitive skill to recognize and distance herself from the experience of the emotive component, exhibits a

strong affective, or engaged, response to her husband's pain and discomfort: "[h]er face scrunches up, on the brink of tears. She's never felt so vulnerable. She's never felt so helpless" (Gutkind 49). Able to recognize and read the wife's emotional response, DeVaney observes that she "would have hugged her" had she been "fresh out of nursing school" (Gutkind 47). DeVaney sees the wife's inability to continue the procedure as further proof that her own method is the right one and works to help get her past that emotive point with an education in "tough love." However, while suctioning out the mucus, the wife "commits the cardinal sin" of looking into her husband's face and seeing it "contorted in pain" (Gutkind 49). Once she sees the pain she is causing to her husband, the wife is unable to continue the medical procedure. This is the result of giving in to the emotional response of engaged empathy. She shares in his pain and cannot bear to continue the procedure. Without the developed skill of clinical empathy, the wife is left defenseless to the contagious effects of empathy, which flood her with emotion; as a result, she is unable to do what is necessary to help her husband.

The juxtaposing of these two instances of the same procedure for the same patient serves as evidence of the usefulness of DeVaney's "tough love" method and further establishes the credibility of not only her claims that a nurse "walks a fine line," one that requires the utmost ability to balance one's emotions, but also Nightingale's "qualities" of a "good nurse." For DeVaney, a nurse does not show compassion with love but with medical attention and care. This is how she regulates her empathy, by acknowledging and suppressing the emotional pull of the emotive and focusing on the cognitive: she is able to understand the discomfort of her patients and she chooses not to engage in it. Rather, she acknowledges it along with her social responsibility to maintain a clinical

distance. Her emotive response is not fully ignored, as she is able to recognize that some

form of a connection does still exist with the patient. She is able to read his reaction of "*I

hate you*" and "*Thank you*"—and to read his wife's emotions as well. If the objective of

clinical empathy is to balance one's own empathy while still being able to provide some

form of emotional connection to the patient, then wouldn't this patient's mixed resonance

be a mirrored response of DeVaney's "tough love?"

Much like the other narratives of nurses to be considered in this chapter,

DeVaney's reflective accounts provide insight into the contagiousness of the empathic

process. It is not simply enough to see how her own process of regulation and distancing

is working, but why it is working. She establishes early on the reality of clinical empathy

as a "fine line" between care and distance, a form of "tough love." Furthermore, she

relates the experience of the wife's inability to walk that same line as evidence of her

giving in to affective empathy which, in turn, caused empathic distress. It is through

these narratives that one can observe the regulation of empathy, and learn, through

metaphors and reflection, the different methods of clinical empathy.

DeVaney later shows that she is by no means completely immune to the

contagiousness of the emotive component and can be overcome with sympathy. She

details an instance in which her emotional defenses are compromised and for a moment,

no matter how brief, emotion takes hold of her. The event takes place in the next room,

where another cancer patient is waiting for the same procedure. Interestingly enough,

when her defenses come down and the plight of a patient becomes real for her, the event

of realization has the markings of someone who is experiencing early symptoms of some

contagious virus or bug:

> All the things to which I'm conditioned to be numb jump out at me. My
> neck flashes with heat. For three fleeting heartbeats of a moment, I think I
> might cry. I pity Roger, yes but equal to that—or perhaps more so—I fear
> becoming him. (Gutkind 52)

The fear of this connection is palpable. The fact that she measures the moment of

emotional connection in her own heartbeats is revealing. The almost cliché presence of

her heart, leading to the overwhelming feeling she might cry, represents a breach in her

emotional immunity. Her neck going flush, complete with the other physical signals,

could easily be those early indicators of a disease in its first stages of development, much

like that first, big sneeze that, like a light switch being flicked on, heralds of an oncoming

cold or that sudden spike of nausea felt in the esophagus that serves as a warning of the

emesis. Her empathic response has led her to emotionally take his place as her cognitive

safeguard fails her. This, one might observe, is what she means by her fear of "becoming

him."

DeVaney has unintentionally broken her own rule and has engaged in the emotive

component, allowing her to "perceive and share in another's psychological state" (Morse

275). What stands out the most is how her observation of the event ends: "I fear

becoming him." She is alarmed at what her pity may lead to—someone open and

vulnerable to suffering. The notion of sacrificing her autonomy, to share in his suffering

as if it were her own, is so frightening for her. That could be an indication of how much

she prides herself on her individualistic ability to regulate her empathy. For nurses like

DeVaney, this is a matter of autonomy. If she were to lose the elements that which make

her an individual in this clinical setting, by giving into the inherent humanistic quality of

the emotive component of empathy and identifying with another in emotional distress,

she will lose her professionalism and ability to provide proper care.

One of the first points to be taken from DeVaney's narrative is that empathy is contagious. It is a powerful form of emotional identification that has developed over the course of our evolution.[18] Evident from her fearful reaction to empathizing with her patient, emotions, like empathy, can be understood as "contagious" through a "process in which a person or group influences the behavior of another person or group through the conscious or unconscious induction of emotional states and behavioral attitude" (Schoenewolf). Although her narrative would lead readers to understand that neither she nor anyone close to her is suffering from cancer, her emotional connection to her patient, Roger, leads her to fear being affected by the disease as he is. Through what can be seen as a contagious spread of emotion, she finds herself influenced by his current state. Like the germs of common illnesses and infections or certain communicable diseases, emotions can spread from person to person, with one person, a *patient zero*, so to speak, having the capacity to change the mood of an entire group of people.

To understand how an individual might take on the emotions of another, by way of that contagion, consider Sigmund Freud's analysis of Gustave Le Bon's observations on "collective mind" in chapter two of *Group Psychology and the Analysis of the Ego* (1922). The term "collective mind" is a way of defining the phenomenon of when an individual, within a group, begins to "feel, think, and act in a manner quite different" from how he or she would "in a state of isolation" (Freud). For Freud, via Le Bon, a group of individuals—defined as a collective with "heterogeneous elements"—combines, even if just for a moment, like the "cells which constitute a living body" (Freud).

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[18] See Adam Smith's "Cognitive Empathy and Emotional Empathy in Human Behavior and Evolution," *Psychological Record*, Vol. 56, pages 3-21, 2006.

Through this combination, those heterogeneous elements become "obliterated in a group" and thus the group becomes homogeneous as the "distinctiveness" of the individual "vanishes" (Freud). Through the contagious pull of the collective mind, an individual sheds his or her individualistic traits or mood to become a part of an emotionally cohesive collective.

In the absence of an explanation from Le Bon, Freud goes on to speculate that there must be a "bond" that allows the "individuals in the group" to "combine into a unity" (Freud). In the case of medicine, I would speculate that this unconscious bond that unites individuals would be the empathy felt for the suffering of another. The contagious, empathic response, triggered in the caregiver by the suffering of a patient, is what could take the individual and bring him or her into the collective mind. Examples of this phenomenon can be observed in DeVaney's narrative in the wife's unregulated response to her husband's pain and in DeVaney's "fear of becoming" her patient. Empathy, is not only contagious but has the potential to threaten the autonomy of anyone who "catches" it.

One of the causes given for this drive for a collective mind is "contagion." Within the setting of a group, "every sentiment and act is contagious," Freud reasons, "and contagious to such a degree that an individual readily *sacrifices* his [or her] *personal interest* to the collective interest" (Freud).[19] The use of the word "sacrifice" brings to mind the connection empathy has with an altruistic or prosocial behavior. It could be seen as altruistic to want to cast off one's own personal interest for the sake of another who is visibly suffering. Appropriately, Freud observes that "[c]ontagion is a

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[19] Emphasis mine.

phenomenon of which it is easy to establish the presence, but that it is not easy to explain" (Freud). What could be observed from Le Bon and Freud's ideas is that, in an effort to regulate empathy, nurses like DeVaney are fighting against an unconscious desire to sacrifice emotional autonomy for the sake of being a part of a collective, a group mind.

To bring a medical perspective on empathy into the discussion of contagion, I refer back to Morse's four components of empathy, discussed in *Exploring Empathy: A Conceptual Fit for Nursing Practice?* The contagious characteristic of empathy can be observed as the emotive component, which allows the ability to "subjectively perceive and share another person's psychological state or intrinsic feelings" (Morse 275). Rooted in the vernacular understanding of empathy as the "ability to understand and share the feelings of another" (OED), empathy in its emotive form is widely viewed as an inherent human quality, one that is seen as a "response" that is "vicariously aroused in an individual when he or she perceives emotional distress within another" (Morse 275). The emotive component is where that perspective taking[20] is enabled, which allows for that "homogeneous" unity.

Within medicine, the emotive component, if left unregulated, can lead to a state known as "engaged empathy," which involves the "experiencing of emotions in parallel with each patient" (Halpern 671). As observed by the theory of collective mind, the act of engaged empathy – at its extreme – would involve a repeated dissolving of autonomy to join in unity with the suffering of each and every patient. To engage in that strong of

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[20] As defined by C. Daniel Batson, Shannon Early, and Giovanni Salvarani, perspective taking can be defines in two ways: 1) imagining how someone feels in a given situation 2) imaging how you might feel in that same situation.

an emotional response with a patient would be to "sacrifice" oneself. Because the proper use of clinical empathy requires various degrees of cognitive distancing, such a deep connection and involvement with "each patient" would be incredibly taxing, or as Halpern puts it, "absurdly demanding," and would put a caregiver on the fast track to compassion fatigue and burnout (671).

Many of the narratives of nurses present the emotive component of empathy as something to build a resistance against, due to its contagious nature. This resistance, or emotional "immune system," is built and fortified in order to avoid engaged empathy or a collective mind and the subsequent burnout or compassion fatigue. I have observed that this building of "resistance" is a strategy of empathy regulation most commonly expressed in the narratives of nurses. The building and then strengthening of an emotional immune system, presented in these narratives, is often framed as a moral obligation. This could be because such emotional involvement and sacrifice would be incredibly draining and thus lead to a compromised ability to perform one's job, evident in the case of the wife being unable to suction out her husband's airway. Thus, it would be a moral obligation, to the patient and the caregiver's ability to perform his or her job properly, to establish that distance and create those barriers.

It is not clear why the framework of the emotional immune system is a concern primarily within the narratives of nurses, specifically, but it may be related to how much time nurses spend with patients compared to the average time doctors, paramedics, and other providers spend with patients, all the while performing an array of intimate

procedures involving hygiene, mobility, and comfort (both emotional and physical).[21]

Such a level of exposure would promote a heavy risk in becoming emotionally engaged

with patients and share in their suffering. Observed in medical narratives, in the world of

nursing, neglecting to protect oneself from becoming "engaged" is often seen as a failure,

often a moral shortcoming.

The notion that one has the moral obligation to be on guard against the contagious

component of empathy and avoid sacrificing oneself to the collective suffering of patients

could possibly find root in the principles of early bacteriology and germ theory. To

examine the clinical notion of an emotional contagion and the responsibility to regulate

exposure, it would be helpful to introduce the theme from which public-health campaigns

of the early 20th century were developed. These campaigns, formed largely in part by

John W. Ritchie and highlighted by his *Primer of Sanitation* (1913), were introduced as a

call to arms for the "never-ceasing war" that wages between "bodies and disease"

(Ritchie 11). As such, any illness resulting from a poor immune system was seen to be

the result of an individual's "carelessness" (Ritchie 191). Yes, people became ill, but it

was the responsibility of the individual to ensure that the disease did not spread. Such

emphasis was placed on the "social responsibility" of the individual to ensure the public's

well-being that carelessness was seen as "the ultimate sin" (Walde 73). Thus, various

"strategies of health management" emerged from further advancement in germ theory

and bacteriology (Walde 73).

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[21] See *Nursing Times*' article "How much time do nurses spend on patient care?" August
14th 2013. https://www.nursingtimes.net/Journals/2013/08/09/h/h/q/140813-How-much-
time-do-nurses-spend-on-patient-care.pdf

To put into perspective the danger of engaged empathy, rather than illness, the contagious component of empathy can be substituted for germs in this "never-ceasing-war" and the use of cognitive distancing for "strategy of health management." Additionally, in illness and disease, people suffer, and it could be said that the suffering should end with the care of the nurse, rather than spread to the nurse, causing the spread or contagious unity. From this view of disease theory, an adequate framework can be constructed for understanding the emotive component as a contagious disease, as it is portrayed in the narratives of nurses. It is in these narratives that shared emotion is the illness contracted by time spent performing procedures that put the nurse within close physical and emotional proximity of suffering. After all, what is the skill of clinical empathy but the implementation of that social responsibility, applied to the practice of medicine. Nurses are given the self-regulatory responsibility to avoid engaging in the "vicariously aroused response" that is the contagiousness of the collective mind. Rather, they are encouraged to distance themselves and use other components of empathy, such as the cognitive and behavioral components, to convey their understanding of a patient's suffering and respond appropriately.

Expressed in the narratives to come, to forget one's "social responsibility" and fully share in a patient's emotional distress is seen as a moral failing of "carelessness," one that can lead not only to the inability to focus and provide adequate care but also to burnout. Therefore, by adopting the individualistic responsibilities found in germ theory, empathy regulation becomes a "social responsibility" for nurses in order to avoid the contagious effects of emotion and free up cognitive abilities. Like the strategies of health management, the strategies of empathy regulation are an individualistic endeavor and

therefore would vary from person to person. However, the expectation of emotional self-regulation places a heavy burden on an already overly-burdened profession and its individual practitioners.

The skill of clinical empathy is, as mentioned earlier, not a science and its methods can vary greatly from person to person and from patient to patient. It takes a great deal of conditioning to be able to distance oneself and like any skill, clinical empathy is not mastered overnight. Much like DeVaney's narrative, the following narratives provide self-reflective examples of the social responsibility to build and strengthen an emotional immune system. Furthermore, the narratives provide very different strategies involving not only the care of the patients encountered, but also the nurses' own method of distancing from their own emotions.

Trauma Junkie: Memoirs of an Emergency Flight Nurse (2001) is a collection of reflective experiences from Janice Hudson, a flight nurse with California's Shock/Trauma Air Rescue (CALSTAR). During a stress debriefing class, aimed at helping medical professionals, it was suggested that Hudson keep a journal in order to "cope with the awful spectacles" she would eventually witness (Hudson 5). It is worth noting that this advice, given in 1990, would coincide with narrative medicine's rise in the late 20th century and serves to highlight the usefulness of narrative writing for medical providers. Her published memoirs are the product of that journal. The very title itself, "Trauma Junkie," exemplifies the enthusiastic drive a flight nurse would possess in order to work outside the confines of a hospital ward, an ambitious desire to be at the forefront of medical care. Therefore, Hudson has had to condition herself differently, having to fly on scene at a "breakneck pace" to care for "critical trauma patients"

(Hudson 6). As a flight nurse, her work blurs the line between nurse and paramedic,

setting her perspective apart from the others in terms of what it means for a nurse to

regulate empathy. Her narrative has been selected for this study to examine empathy

regulation from a nursing perspective outside of the controlled environment of the

hospital.

Hudson is able to provide observations of her own methods of empathy

regulation; additionally, she is able to examine them in relation to the strategies of her

colleagues. This ability allows for a deeper understanding of her own strategies. For

instance, Hudson is able to see the seemingly harmonious implementation of clinical

empathy by Rose, a fellow flight nurse. She sees within Rose a humanistic method that

seems to be without distancing and admits to the envy she feels for that ability to have a

deeper connection to patients:

> Rose always maintains a calm exterior. She is also acutely aware of the
> human side of our care, reminding us these are not simply bodies we are
> salvaging, but human beings with lives and families. Her perspective
> calms patients, families, and co-workers, and I often wish I could emulate
> her style. Unfortunately, if I allow myself to consider the personal lives of
> my patients, I can't concentrate on the work at hand. It becomes too
> painful. (Hudson 159-160)

Rose personifies what seems to be the perfect balance of professionalism and empathy.

Hudson is aware of the humanistic quality of Rose's work, apparent in her ability to see

patients as more than anatomy. To see the patients as human and to see the connection

they have to their families is a form of respect that comes with a humanistic approach.

The description of Rose's ability to be "acutely aware" shows an understanding of the

behavioral component of empathy, the "communicative response" to "convey

understanding" of a patient's "perspective" (Morse 274). Beyond being able to

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understand that these patients are "not simply bodies," the use of the behavioral component allows for the "ability to communicate" that "empathic understanding" (Morse 275).

Hudson's narrative observations of Rose could be personified in what Priti Lakhani, a healthcare executive and physician, believes to be the ultimate meaning behind empathy in medicine: "being respectful" (Lakhani). She treats her patients and their families with a respect that humanizes them and, through that connection, is able to give reassurance to those around her. Additionally, what Hudson can see in Rose is a balance, as evident by her "calm exterior." To view a shock or trauma patient, in a state of near-death, as someone with a family and aspirations, and not just a list of symptoms, complications, and injuries, without breaking down, is no small feat. Hudson, through her experience, knows this. She "wishes" to have that same emotive connection Rose exhibits, but she perceives that empathic balance to be personally unobtainable. Unable to let down her emotional defenses and "consider the personal lives of [her] patients," she makes an individualistic, cognitive choice to shut out any emotive response she might feel. At first glance, this level of distancing may appear insensitive; however, Hudson has had to build her immune system differently from most nurses due to her job: as a flight nurse, her patients may often be on the brink of death and she feels that she cannot risk her ability to "concentrate" on the task at hand. Like in DeVaney's example of fear, to dissolve her autonomy and catch the suffering of one of her patients could seriously compromise her ability to save a life.

Readers can observe Hudson reflecting on her own strategy, which she classes as a perceived inability to be more empathic with patients after she witnesses other

emergency personnel (firefighters, paramedics, and police) react callously to the victim

of a drug deal gone bad. The first responders have built up their own emotional immune

systems; observing their reaction to a shooting victim, she recognizes the same level of

distancing in herself:

> Our patient died later that night. He was found to be HIV-positive,
> decisively precluding him from organ donation. The shooting turned out
> to be over a quarter gram of crack. This man was someone's son, brother,
> husband, friend. And yet I found myself surprisingly unmoved. I simply
> found the whole incident a stupid waste of life. I guess I've built a bit of
> an emotional bunker for myself. (Hudson 46-47)

For Hudson, had she allowed herself to lower her immune system's defenses and

participate in the emotive component to be "moved" by the death of the young man, and

every patient like him, she feels as though she might succumb to burnout or be unable to

"concentrate" on her job. If she were to allow herself to "consider this patient's life," she

might dwell on the regrettable path that led this young man to his premature death.

Instead, to a great deal, she cognitively distances herself from the patient and looks at

him, as he is now, a "waste" of potential. She understands and recognizes the distress

that this loss of life creates, prompting a cognitive response either to engage or to

distance herself. As part of her perceived "social responsibility" and to avoid the

contagious effects of empathy, she chooses the latter and distances herself from the

distress of another. One might observe her use of the word "bunker," rather than

"barrier" or simply referring to her regulation as distant. The militaristic sense of the

word bunker would lead readers to note the authority it brings with it and recognize how

strong her emotional immune system needs to be. For the sake of survivability, she has

fortified herself behind hardened walls, much like the other first responders. However,

perhaps because she is readily able to identify her own defenses, she sees herself as

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capable of some form of behavioral or emotive responses that would display a sympathetic quality. After all, she refers to her "bunker" as incomplete, partial, or maybe just situational, as evident by the word "bit." It maybe she only hides behind a few fortified walls. She has not committed herself to a psychic numbing.[22] She shows the presence and possible emergence of compassion still in her. She is not suffering from burnout. The immunity she has built up has kept her at an emotional distance from which she feels relatively comfortable and safe enough to do her job.

Much like Hudson's insightful ability to explore the strategies of her empathy regulation through narrative, the following narrative presents the same level of insightful awareness; however, it does so from a different environment: the emergency room and hospice care. This narrative, like DeVaney's, was selected from a collection titled *I Wasn't Strong Like This When I Started Out: True Stories of Becoming a Nurse* (2013). Making the claim that nurses represent the "backbone of the healthcare system," the collection features mindful accounts of nurses working through "all stages of their careers" while highlighting the "requirements" of being a nurse: "empathy, fortitude,

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[22] While observing the other first responders and what would seem to be their insensitivity to tragedy, Hudson explains that "they witnessed man's inhumanity to man over and over, day after day. In order to cope with this brutality, they learned to build a thick insulating shell around themselves. Even the most macho of men must go home and cry alone in a closet after they've seen a murdered toddler or heard a burn victim screaming in agony. Building an enormous emotional bunker is the only way they can survive" (Hudson 46). In order to "cope" with the trauma of being a first responder in a large city, these individuals have had to work with a degree of "psychic numbing" akin to what Robert Jay Lifton observed in rescue workers in Hiroshima after the atomic bomb dropped. The mantra of psychic numbing is "[n]umb yourselves some more, don't feel; above all, don't question" (Lifton 620). See Lifton's "Beyond Psychic Numbing: A Call to Awareness," American Orthopsychiatric Association, Inc. 1982.

knowledge, and grace" (Gutkind).[23] The two narratives chosen are examples of the

book's claim.

Not all nurses are as comfortable with the notion of emotional distancing and

becoming "numb" to the bonds of empathy and strengthening their immune system, as

observed in the previous two examples. Some nurses still fight to hold on to that

connection created by the emotive component and remain emotionally engaged to

patients for various reasons. Kimberly Condon, a fourteen-year veteran of emergency

medicine at the time of her narrative, examines her struggle with empathy regulation in

her essay "Approaching Death." She describes herself as "overly sensitive" and,

providing an excellent example of the moral component, chose nursing because she

appreciated the feeling of being someone that people could "lean on in times of crisis"

(Gutkind 244-245). Her rationale for becoming a nurse is the result of a strong moral

component to her personality. A "prerequisite for humanistic relationships," the moral

component has guided her to healthcare as a deliberate process to "reach out to help

people" (Morse 274). Her moral empathy is quite strong, as the "suffering of others" has

always provoked a response in her (Gutkind 244). Additionally, her emotive component

is highly developed and using it aided her, making her a nurse "who had a gift" for taking

on the emotional state of another, for "sensing what a psychotic patient needed in order to

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[23] The outward, public "image" of nursing and its psychological impact on nurses is a
topic that has been given a considerable amount of attention. According to a study
conducted by Miyuki Takase (*Influence of Public Image of Nurses on Nursing Practice,*
2000) nurses not only struggle with a deprived levels of autonomy due to their but also
struggle with obstacles, "not from within the profession but from their stereotypical
occupational image." For more on this subject, see Collins and Henderson's *Autonomy:
Part of the Nursing Role?,* 1991 and Buscherhof and Seymour's *On my own terms: the
Redefinition of Success in Nursing,* 1990.

de-escalate"; she was the "one to call when a battered woman needed to feel safe enough to talk" (Gutkind 244). She seemed to pride herself on her ability to dissolve her autonomy and share in the contagious suffering of patients. Now, after years of working in the ER, she considers herself regrettably callous and remembers how she was when she first started: "ma[king] it a point to touch every patient, even when she wasn't examining them" (Gutkind 244). There is a deep sadness and longing in her words as her narrative looks back on how she has changed. In contrast, DeVaney looks back on how she might have hugged her patient's wife if she were just out of nursing school; Condon, on the other hand, does not want to let that empathic connection go. The emotional distance she has had to develop is described as her "edges [beginning] to wither," as she feels a "hardness creeping in" (Gutkind 244). Such imagery might bring to mind the death or dying of something. She seems to view her empathy as if it were being suffocated or deprived of the chance to grow and flourish, much like a plant's leaves that begin to wither and brown before drying up into husks. This hardening of emotions might lead readers to believe that her empathy is diminishing, if not being completely scarred over by compassion fatigue, but it could very well be that this is just her learning to create cognitive distance between herself and her patients, something she is not comfortable with. This "callous" numbing is described in the introduction as a "simple strategy" of "[b]uild walls and stay busy" (Gutkind 243). But is it simple? Such a coping process for an already emotionally driven and empathic individual may feel foreign and saddening. After years of "building walls," she becomes aware of the foreign and uncanny feeling this emotional distancing has created for her: she observes that she "felt like [she] was floating through someone else's life," she "felt like a fraud" (Gutkind 245).

What stands out most about her reflection here is that she feels like "someone else" and a "fraud" by not sharing in her patient's experiences and giving into the contagious pull of the group mind. Rather, by not dissolving her autonomy she feels like a stranger in her own body.

The amount of regret she expresses for being unable to create that emotional engagement with patients shows that her capacity for empathy is still very strong. There is something very troubling about her narrative experiences with empathy regulation. Her narrative seems to give no evidence of any sort of regulation when she was "deescalating" patients and making abuse victims feel "safe." If one is to understand that empathy needs to be regulated in order to work within medicine, what could be said about a nurse who is strongly empathic and could use an unregulated emotive component effectively within her job? Condon's narrative seems to suggest that her empathy, unregulated, and her immune system's walls unbuilt, served her and her patients far better than if she had built defenses and created distance.

After leaving the ER to work in hospice, she worked with a family and their six-week old baby. The baby died and her reaction still exhibits a strong foundation of the emotive component as she takes on the suffering as if it were her own child:

> I felt myself losing control, choking and sobbing as if her were my child, my loss. I didn't even have children. I tried not to make noise, tried not to trespass on their moment. I was so ashamed! I was supposed to be their support, their rock. […] I couldn't believe what a failure I was. (Gutkind 248)

Here, what can be observed is an example of engaged empathy at work. By reacting as if it were her child, Condon is engaged in that instinctive emotive component that is seen by many as a "careless" breach of "social responsibility," and she harshly labels herself

based on this "moral failure." What is important to note is that she begins by stating that she "lost control," giving into the contagion and acknowledging that even though it feels awful and callous, distance is a form of restraint and discipline. It is difficult to say whether anyone who is this strongly empathic could comfortably mold themselves to the expectations of clinical empathy and still feel comfortable and confident working with patients. She sees the process of building an emotional immune system in terms of property and structures, much like Hudson's bunker. By sharing in this tragedy, she has broken down the "walls" she has "built" and has entered into their "moment," a movement she views as "trespassing," something to be "ashamed" about. Through her years in the ER she has come to view emotions as things that should have clearly defined borders and fences to keep them separate between individuals, something not to be shared. Much like an illness that needs to stop at the individual by way of a social responsibility, Condon still uses a hyperindividualistic lens through which to view emotions in medicine in combination with the "social responsibility" to not share in emotional experiences, which would result in the "cardinal sin" mentioned.

Feeling its effects and wanting to avoid the result, Condon leaves emergency medicine for a job in hospice to avoid burnout.[24] It is there that this unfortunate narrative of the child's death comes from. She looks back on that event and she describes her actions as being "absolutely present" for the parents and their dying child (Gutkind 249).

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[24] One might reasonably see why hospice might have seemed like the best switch as Condon expresses her disdain for the fast-paced and impersonal world of the emergency room, but according to recent studies, hospice workers experience a great amount of burnout and grief (though not as much as those who work in the ER) due to the deep connections and relationships made between patient and caregiver. See N. Sardiwalla's "The Role of Stressors and Coping Strategies in the Burnout Experienced by Hospice Workers," *Cancer Nursing*, December 2007.

She arrives there as a trained and qualified medical professional and is there for them, physically, in the room, and beyond that, her use of the emotive component of empathy allows her to be present in a way that not many nurses may have felt comfortable. She is present with them by sharing in an "agonizing and priceless" moment, by an emotional means made possible through a contagious bond, developed through years of evolution and human development. Through it all, she recognizes the imperfection of being engaged by saying: "It was the best I could do" (Gutkind 249).

Empathy as a contagion, an emotional virus that spreads from host to host, is a common drive behind regulating the empathic response within many accounts of nursing. The concern lies in engaging in affective contagion; it is feared that a nurse would be overcome with empathic distress and thereby unable to properly care for patients. Therefore, it seems to be common practice to "build walls," "bunker" down, or make oneself "numb" to the emotional responses that come with witnessing another in a state of suffering. Metaphors seen in the narratives examined, such as the practice of clinical empathy being a tightrope or fine line and distancing being an immune system or housing structure, provide information that will likely be understood by the general public.[25] Such metaphors can make very complex subjects, such as empathy and burnout, accessible to a general readership.

The narratives in this chapter provide familiar metaphors to facilitate mental images of abstract concepts. Contagions and immune systems are all readily accessible

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[25] Kathryn Singh, in her essay "Metaphor as a tool in educational leadership classrooms" (2010), explores the educational benefits of metaphors as part of a strategy to bring abstract concepts to a "concrete representation" for audiences to compare to something "familiar."

representations that can help foster understanding of complex subjects such as empathy

and the process of regulating it. In order to convey how difficult and distressing it can be

to regulate empathy, Condon describes her cognitive distancing as a "hardness creeping

in" as her "edges began to wither." Emotional distancing is not an easy task for

everyone, and it would be helpful to understand the distress it could cause. Hudson, a

nurse working in a high-stress, fast-paced environment, felt that she needed to be more

conservative with her empathy and fortified herself in a "bunker," a far more drastic

means of immunity than building "walls." Walls are not enough on the warfront.

DeVaney, though confident in her ability to use her cognitive distancing while still able

to place herself in her patients' perspectives, shared a moment when her immune system

was compromised and "[a]ll the things to which [she was] conditioned to be numb

jump[ed] out at [her]." The conveyed breach of emotion provided insight into how even

a second of affective empathy could prevent a nurse from functioning in his or her

distress. It is with an examination of these narratives, in addition to the numerous others

in and out of print, that greater understanding could be brought to the practice of clinical

empathy.

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