

'Across the bay I heard the surgeon ask about the decorative button sewn delicately onto a night gown allowing access to the wound where a breast once was. He tried to garner interest from the anaesthetist in the family story of the button's creation. I breathed in the humanity as I waited for him to come round to me with news of my op.' (Louise Younie, cancer experience reflection, 2019)

The clinical encounter sits at the heart of all medical practice. This may be a place of short exchanges, evaluation, and explanation. It may also be a sacred place of hope or despair, a liminal space that sits somewhere between life and death, a sharing of vitality, fragility, and mortality.¹

The complexity and wonder of the individual patient encounter should not be underestimated. A collision of two — sometimes more — diverse universes of lived experience, seeking, in a short space and time, to work together on some of the most life-defining, world-fracturing experiences that patients go through.

MEETING THE OTHER AS SUBJECT OR OBJECT

In this article we consider the 'selves' present in the clinical encounter² and how creative enquiry can help to open up the space in-between, a space that is owned by neither but which might be shaped by both.³ Winnicott⁴ has termed this space 'the third space', within which the contours of self and the other might be perceived, where mutual assertion and recognition might lead to the emergence of meaning and fresh perspectives.³ Attending to this in-between space invites engagement with the patient as an experiencing subject, an 'initiator and ... collaborator' rather than an object of study.⁵

Buber,⁶ a Jewish philosopher and

theologian of the 20th century, helps us to think about the degree to which we meet the other as subject or object with the terms 'I-Thou' or 'I-It' relating to these different orientations.

In 'I-Thou' relating, people seek to engage, subject-to-subject, whereas 'I-It' relating involves the objectification of the other.

Over a decade ago, Louise Younie introduced creative enquiry into the GP placement at the University of Bristol where first-year medical students could opt to explore a patient's lived experience creatively.⁷

One student produced a photograph (image above, right) exploring the patient narrative. She described the impact of chronic ill health on a father:

*'He explained to us how ... he had contemplated suicide ... several times he had "lined up the pills on the table" ... as he sat ready to take an overdose, he had seen his child's toy car on the table ... that gave him the will to continue ... every person needs hope and a reason to persevere and that strength is often found in people, not science. In this photograph I have used colour, or lack of it, to demonstrate this.'*⁸



Emergency by Abigail Lewis-Barned. <http://www.outfourheads.net/oooh/handler.php?id=379>.

THE PATIENT'S TESTIMONY

In this striking image, the pills are foregrounded and large, and the toy car is out of focus in the background. The creation of an image not only allows the slowing down of perception, taking the time to really look, but the created image can also be powerfully evocative, using symbol, colour, and focus to develop understanding and facilitate further dialogue and exploration. This example illustrates how creative enquiry may nurture experiential, aesthetic, and practice-based knowledge construction⁹ by inviting students to engage with their own seeing, listening, and interpretive framing as they interact with their patients.

Creative enquiry into patient narratives can therefore enrich understanding of the (inter)subjective biographical realm where the parameters are metaphysical (for example, hope, despair, and fear),² and in this way reinforce the patient as subject rather than object in the eye of the student.

In the following extract another first-year medical student explores the biographical realm through creative writing and 'trying out the patient's shoes':

'I remember what I felt emerging from the neurologist's office ... I was ... relieved to finally have a diagnosis, at last someone

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recognising that there was something actually wrong with me ... It had taken them over a year to figure it out, a year of me bounced between hospitals and arrogant consultants, poked and prodded and tested like I was a monkey about to be shot into space. All the time I had doctors brushing it aside; “oh it’s probably nothing more than such and such”, they said dismissively like I didn’t know what I was feeling in my own body. (George Wellby, 2010)¹⁰

In this narrative the student attends to the dismissal of the patient testimony. Patients themselves attest to similar experiences. Toombs¹¹ describes negation of her bodily symptoms prior to her diagnosis of multiple sclerosis. In disappointment at the inconclusiveness of her muscle biopsy she put it to the physician that little had been gained by performing the procedure:

“Oh but we have! [gained something] Now we KNOW something is wrong” countered her physician.”

Toombs ‘knows’ her bodily dysfunction, but the clinician attributes lower value to this embodied ‘subjective’ knowledge in this brief interpersonal encounter than to the ‘objective’ knowledge that emerges from the test. These two narratives illustrate epistemic injustice — wrong done to someone specifically in their capacity as knower, a phenomenon that is all too common in medical practice, whereby a patient suffers an unfair credibility deficit, by virtue of being a patient.^{12,13} Creative texts can surface and make visible concepts such as epistemic injustice that might otherwise remain ‘inarticulate’ in the professional culture of practice.

HEALTHY SELF-EVALUATION

Countering epistemic injustice is an approach of ‘epistemological humility’ identified in the practice of culturally sensitive social workers.¹⁴ It is an approach to practice that honours many ways of knowing and multiple, diverse standpoints from which to view reality. DasGupta¹⁵ proposes the concept ‘narrative humility’, which is a similar idea. It is the understanding that we

can never fully comprehend the complexities and intricacies of another’s story, which only ever approximates another’s self.

Creative enquiry can support the development of epistemological or narrative humility by creating space for healthy self-criticism and by inviting the evaluation of practice from a disconfirming stance.

One student used modelling with creative materials to explore an occasion of heavy-handed consultant-led delivery of bad news to a patient in front of the medical team (including the students). An unsettling experience that had been partially swept under the carpet of consciousness found the space to be shared and reframed.

After a postgraduate creative enquiry workshop, a doctor described the transformative power of a creative writing exercise where she imagined herself to be an agony aunt, responding to a letter sent to her from a particular nurse with whom she had experienced ongoing relational difficulties. This unearthed new viewing points and new ways of understanding and dealing with the situation.

EPISTEMOLOGICAL HUMILITY

Engagement with creative enquiry can expand our reflective engagement regarding the encounters we have with patients. Personal expression captured through the arts allows the clinician to recognise their situated and positioned nature as a doctor and their choice in how they position their patients (through I-It, I-Thou ways of relating). It may foster movement away from what may be an unintentional philosophical approach resulting in epistemic injustice — a natural consequence of the positivist orientation to understanding disease — towards a position of epistemological humility, in which the practitioner is equipped to engage more meaningfully with people in their suffering and illness.

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DOI: <https://doi.org/10.3399/bjgp20X707549>

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