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Empathic Communications and Narrative Competence in Contemporary Medical Education

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Abstract

Lindsay Holmgren's "Empathic Communications and Narrative Competence in Contemporary Medical Education" reviews the teaching of narrative competence in medical education, arguing that these practices must engage postclassical approaches to narrative studies while attending to the concept of empathy as it is deployed in various disciplines, including narratology, cognitive science, and psychology. With an emphasis on the formation of professional identity in medical practice, Holmgren explores the relationship between professional identity in a multi-ethnic, gender-neutral, demographically and culturally diverse medical education context, and the complex arena of narrative empathy. Hinging on the reciprocal nature of identity that emerges at the intersections of various versions of the self and others, Holmgren's article aligns the empathy developed by reading fiction with that which develops in the clinical encounter. Finally, the article understands these various, evolving subject positions rhetorically, arguing that the comportments of medical educators in the humanities should be such that their students will want to emulate them.

Keywords

Postclassical narratology; narrative competence; narrative empathy; medical humanities; professional identity

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The practice of medicine is fundamentally prosocial. Upon this premise the present essay rests, and what follows is imbued with its significations. Moreover, medical educators and accreditation bodies, as they determine the practical and theoretical strengths of North American medical institutions, implicitly recognize that which underlies this prosocial premise: the importance, indeed the urgency, of recuperating the empathic dispositions to which so many medical students were given when they decided to become physicians. Rita Charon's pioneering work in what she first called "narrative medicine" at Columbia University's Medical School, alongside various applications of the medical humanities and narratologically driven medical education at such institutions as McGill University, The Ohio State University, Dartmouth, and the University of Toronto attest to the increasing relevance of narrative, and the medical humanities more broadly, not only to theoretical medical education, but also to clinical medical practice.[1] What continues to preoccupy narrative

[1] Charon coined the term "narrative medicine" in her 2001 *JAMA* article, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." There, she outlined some of the qualities and benefits of an approach to the practice of medicine that involved attending to the nuances of story produced both by patients and their physicians.

theorists and medical educators alike is the question of whether a positive correlation between "narrative competence" and the various forms of empathy—motor, affective, and cognitive—is substantive enough to merit designating protected educational time to the enhancement of narrative competence. Moreover, it is debatable whether or not an enhanced capacity for empathy in fact gives rise to prosocial behavior in the sense in which I characterize the practice of medicine.[2] Finally, and in this vein, while practices for measuring one's empathic capacity exist and are the foundation for much research on empathy, not all institutions measure medical student and physician empathy.[3]

To be sure, despite its introduction into medical education almost fifty years ago with Pennsylvania State University medical school's 1967 inauguration of a department of humanities, the medical humanities discipline has garnered little quantitative evidence that concretely demonstrates its long-term benefits in nomothetic terms. In Donald Boudreau and Abraham Fuks's assessment, education in the medical humanities has "unfolded in phases. The 1960s to 1980s featured literature and philosophy. Studies in philosophy gravitated away from epistemology and metaphysics towards axiology and deontology . . . Of late, the nature of literature in medicine has taken on a new dimension—that of narrative competence," citing Charon's 2001 "Narrative Competence" article, as well as our article of 2011 on narrative and medicine (Boudreau and Fuks 325 [Holmgren et al.]). Three major studies of medical humanities called attention to the lack of evidence pertaining to the long-term impact of integrating humanities into medical education,[4] but the studies received criticism for "imposing 'a homogeneity on the medical humanities that does not exist' through its reductivism, ambiguous groupings, overly broad definitions and fallacious comparisons . . . Thus, exploration of the efficacy and utility of medical humanities teaching appears to have reached an impasse" (Dennhardt et al. 285-6). The impasse, I argue, appropriately situates educators teaching empathic communications in medical settings, for much of the value of humanities educations, including critical aspects of personal and professional development, lies in that which resists most conventional metrics: as Boudreau and Fuks rightly put it, "interventions of a subjective or values-based nature are not amenable to standard assessment protocols"—protocols that are nevertheless central to the creditable administration of strong medical programs (327). The resulting paucity of evaluation data on the impact of a medical humanities education underscores the legit-

[2] Empathy is of course a cornerstone of good medical practice, as William Osler long ago assessed, stating that the physician's work was "constantly appealing to the emotions and finer feelings" (qtd. in Berg et al. 105). Thus the Jefferson Scale of Physician Empathy is used worldwide to test medical student and physician empathy levels. Additionally, such measures as the Toronto Empathy Questionnaire (TEQ) and the Reading the Mind in the Eyes test have been used in medical schools to assess empathic capacities of students ("The Toronto Empathy Questionnaire"; . However, its relationship to empathy as developed through narrative is what's at stake here. As Suzanne Keen, eminent scholar of the relationship between narrative and empathy, once asserted, "it will not suffice to rely on assertions of authors, on introspection, or on personal conviction to prove that reading certain canonical works of fiction inevitably yields the cultural and civic good of altruism and engaged world citizenship" (*Empathy* 145). More recently, however, Keen asserts, "Propositions, derived from the science of real-life empathy, included changed attitudes, greater tolerance, reduced fear of the other, and increased helping behavior or altruism" ("Intersectional" 125).

[3] My home institution of McGill, for instance, does not use the Jefferson Scale (see footnote 1).

[4] See Ousager J, Johannessen H. "Humanities in undergraduate medical education: a literature review"; Perry M et al. "The effectiveness of arts-based interventions in medical education: a literature review"; and Schwartz AW et al. "Evaluating the impact of the humanities in medical education."

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imacy of an iterative approach, which has led medical educators through literary and philosophical pedagogies and toward narratological ones. It would seem, therefore, that it is now "narrative medicine," understood within the larger arena of the medical humanities, which bears the weight of evidentiary lightness.

But if the global community still values humanities educations, and if responsible educators—whose training is in the humanities, who have taught in humanities departments, and who continue to invest in the development of critical thinking and compassion in which the humanities are invested—are building and teaching humanities curricula in medical programs, it follows that such curricula will deliver value to a practice involving relationships between two or more human beings; namely, medicine. More narrowly, if narrative theorists—whose backgrounds are in literary studies and pedagogies whence narrative approaches to the medical humanities evolved—are designing and implementing curricula to foster narrative competence, such curricula ought to be able to help practitioners achieve related competencies. With such positions and paradoxes in mind, I will discuss the relationships among narrative competence, professional identity, and empathy, as well as how these categories fit into the larger arena of the medical humanities in practical, pedagogical terms. What follows will include research-oriented, theoretical, and anecdotal evidence in an effort to expand the considerable body of literature on the teaching of narrative competence, especially as it is understood within the larger arena of the medical humanities. Ultimately, I will argue that narrative competence built on the theoretical foundations of postclassical narratologies[5] will be essential to the long-term sustainability and requisite mutability of medical education.

1. Narrative, Professional Identity, and Trust: Contexts and Conditions

An empathically receptive state can generate a shared sense of experience from which medical practitioners are poised to benefit both their patients and themselves. Often discussed in terms of its worth to patients, empathic medical treatment might be every bit as important to physician wellbeing and professional development as it is to effective patient care. Medical students and residents tend to find themselves inoculated against this species of empathic engagement in a transition, Charon has observed, that they recall in terms of "sadness, rage, and contrition" ("Narrative Medicine" 84). Small though her test case might have been relative to all accredited medical schools at the time of its publication, Charon's observation regarding her students' experiences accords not only with those I've encountered at my home institution of McGill University, but also with those of my colleagues at various North American institutions. Unfortunately, the medical practitioner's

[5] The title of his 1999 volume, *Narratologies: New Perspective on Narrative Analyses* bespeaks David Herman's seminal approach to understanding various approaches to narrative theory as multifarious, diverse, and post-structural in a manner akin to those texts that moved from a discussion of "modernism" to one of "modernisms"— various, different, and irreverent as they were, and indeed needed to be. From Herman's text does Jan Alber and Monika Fludernik's *Postclassical Narratology: Approaches and Analyses* (2010) explicitly take its cue, collecting essays that approach narrative studies through cognitive, queer, ethnic or minority-related, poststructural, and postcolonial lenses. More recently, in *Narrative Theory Unbound* (2015), Robyn Warhol and Susan S. Lanser call for a shift in emphasis from the classical terms "narratology" and "narrative theory" toward "narrative theories" and "narratologies"—classical and postclassical—in an effort to accommodate the differences (ethnic, sexual, gendered, demographic) to which a fuller approach to the study of narrative attends (1-9).

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enhanced sensitivity to alterity and to her own human condition, augmented by the mutually enriching effects of interpersonal connection, significantly receded with the cleaving of modern medical practice from ancient medical praxis invested in *humanitas*, or "love of mankind."[6] I'd like to emphasize the degree to which medical students and practitioners, for whom a primary mortality risk is suicide, could benefit from viewing personal connection with patients as an end in itself, regardless of diagnostic or prognostic outcomes.[7] If we accept such connections as intrinsically valuable to patient and provider alike—however vulnerable they briefly might render the physician[8]—then we must ask how to recuperate the empathy in which such connections inhere; thus, we return to the challenging question of narrative and empathy, inflected now with the relationship between narrative and personal identity.[9]

In the medical arena today, professional identity is central to the development of the medical student's or resident's role—namely, as the "physician-professional" (the counterpart to the physician-healer)—as well as to improved customer service, the latter an especially critical concern in the privatized system of the United States.[10] In other words, an emphasis on the *developmental* aspects of the discipline will be as significant a benefit of medical humanities educations as the *instrumentalist* ones. In an *Academic Medicine* article of 1997, Richard Cruess and Sylvia Cruess called for closer pedagogical attention to the development of professional identity. There they argued, "It is the responsible behavior of the [physician-]*professional* that will protect the role of the [physician-]*healer*," and they aligned the professional aspect of the practitioner's role with moral standing and authority

[6] Boudreau and Fuks remind us that "[h]umanism has been seen as constitutive of medical practice for over 2,000 years. Between 44 and 48 A.D. Scribonius Largus, writing a commentary on medicine, considered that medical practice has three char- acteristic features: humanitatis (love of mankind), misericordiae (mercy), and professionis voluntatem (the purpose of the profession) (Hamilton 1986)" (322).

[7] The content of programs such as "Finding Meaning in Service" (FMS) and related support groups attest to medical practitioners' and educators' growing recognition of the value inherent in the doctor-patient relationship.

[8] Worth noting is the relationship between agency and empathy. An *affective* empathetic connection, whose endocrinological, visceral responses might be ignited against the interlocutor's (in this case, physician's) conscious will, might be understood to destabilize the objective subject position the physician must retain. Thus, training in navigating the relationship between feeling with and remaining objective is critical in the training process. Moreover, as Suzanne Keen notes in *Empathy and the Novel*, what we might call the darker side of empathizing can edge close to the boundary of dissociation (not to be equated with dissociative disorder) such that one's connection to her immediate context is jeopardized (*Empathy* 128-9).

[9] For my purposes here, personal identity should be understood as part of a phenomenological tradition stretching from Edmund Husserl to Martin Heidegger and, most critically, to Emmanuel Levinas's articulations in *Alterity and Transcendence*. To some extent, the typically Western resistance toward facing the inevitability of death, which has much to do with the challenges faced in the medical humanities, highlights the value in addressing Levinas's characterization of the finitude of the *other* as part of her perceived alterity, while also functioning as that which unites the self to the other. "But that face facing me, in its expression—in its mortality—summons me, demands me, requires me: as if the invisible death faced by the face of the other—pure alterity, separate, somehow, from any whole—were 'my business'" (24). Ideally, that summoning could lead to a transcendence by which physician and patient would share the uncovering of "health" as something *other than* the mere avoidance of death. Moreover, this rendering of personal identity, which is crucial to professionalism in the medical arena, accommodates notions of the relation between self and other elucidated by Paul Ricoeur in *Oneself as Another*.

[10] See Cruess RL, Cruess SR. "Teaching Medicine as a Profession in the Service of Healing. *Acad Med*. 72.11 (1997): 941–952.

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(941, emphasis mine).[11] The role of professional identity formation has since become a pillar of medical education from an evaluation and accreditation standpoint;[12] therefore, a richer, more transcendent[13] means by which future physicians might develop nuanced, meaningful professional identities increasingly commands (or ought to command) the attention of medical educators.

Historically central to Western pedagogies of identity formation is self-writing: from paragraphs about family vacations in primary school to "personal reflections" on class readings in universities, assignments requiring the student to narrate the self and her relationship to the world persist. Medical educators are now more frequently employing this tool to enhance their students' clinical development of so-called soft skills—a debatable term for what narrative competence engenders. In a 2016 *Medical Education* article, Virginia Cowen, Diane Kaufman, and Lisa Schoenherr's review of "reports on the use of creative and expressive writing in US medical education" show that while the practice "was identified as a potentially relevant pedagogical tool," it remains predominantly part of electives or clerkships and peripheral to required curricula (Cowen et al. 311). According to the authors, the self-expression, organization of thought, and observational and descriptive skills creative writing develops "assist with a more thorough diagnosis and understanding of the bio-psycho-social-spiritual complexity of patients, and also influence patient compliance and treatment."[14] The "soft-skill" epithet might have something to do with some medical educators' and curriculum developers' attitudes toward writing and critical thinking more generally, but displacing these skills into the category of the "soft," I would argue, is misguided. Taking an effective history, knowing which information to retain and which to set aside, and recognizing those aspects of narrative that bespeak the central concerns of a story are, after all, crucial—not to mention cost-effective and time-saving—requirements of effective healthcare, especially in the arenas of primary care, internal medicine, neurology, pediatrics, and many other specialties whose emphasis on "the narrative" is dominant. Creative writing, and especially self-writing, is the key here. That Charon and others who are teaching narrative approaches to medical education frequently start by having their students write about personal experiences which are often, but not always, about medical or health-related events thus answers to two calls medical education now makes: (1) the call to improve self-awareness essential to personal and professional identity formation; and (2), the call to improve one's narrative competence and, by extension, one's

[11] Ibid.

[12] See, for instance, texts to which Cruess et. al call our attention in "Reframing Medical Education": (1) Liaison Committee on Medical Education. Regulation MS 31A. In: "Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree"; (2) Frank JR, Danoff D. The CanMEDS initiative: "Implementing an outcomes-based framework of physician competencies"; and (3) Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements. 2007. http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf. Accessed July 10, 2014.

[13] See footnote 8

[14] Their language here regarding "influence" points up the relevance of rhetorical narratology in medical education as it has recently been elucidated by James Phelan and Richard Walsh, for instance, but dating back to early formulations thereof by Wayne Booth. (See Phelan's *Narrative as Rhetoric* and *Living to Tell About It*, Walsh's *A Rhetoric of Fictionality* and "Person, Level, Voice: A Rhetorical Reconsideration," and Booth's *The Rhetoric of Fiction*).

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capacity for empathizing with the other, thereby building trust in relationships with colleagues and patients.[15]

Indeed, the rise of professional identity formation to a pillar of medical education must be understood in light of other pressing elements of program accreditation, quality, and ranking: those associated with empathy, compassion, and trustworthiness. In a 2014 *Academic Psychiatry* article, Michael Devlin and his colleagues note that "As health care becomes more and more marked by social, behavioral, and existential dimensions like social determinants of health and spiritual beliefs about death, physicians need to develop skills to discern, weigh, recognize, and respect multiple perspectives, including but not limited to their own" (Devlin et al. 669). As the authors suggest, the Accreditation Council for Graduate Medical Education core competencies and milestones, as well as the Royal College of Medicine, and the Association of American Medical Colleges' Physician Competency Reference Set (PCRS) all explicitly require that medical practitioners are, at the very least, competent in attending to and comprehending their patients' experiences regardless of ethnic, sociopolitical, religious, or other predominantly ideological differences. According to Harvard Medical School's Michelle Dossett and her colleagues, in fact, "the Accreditation Council on Graduate Medical Education (ACGME), American Board of Internal Medicine (ABIM), American Association of Medical Colleges (AAMC), and the Institute of Medicine (IOM)" all assert that "professionalism, humanism, effective communication, and the ability to collaborate with other allied health professionals as a team are valuable and important physician competencies" (Dossett et al. 292). Unfortunately, they continue, while these bodies "have set guidelines around the inclusion of these topics in training curricula and their measurement," formal training remains "underemphasized." Nevertheless, forward-thinking medical educators increasingly hold that writing about her own life and the lives of others can help the budding physician develop self-awareness and practice empathic perspective taking, thus developing a compassionate professional identity.

Such an approach must take into account the historical Anglo-American problem of classism in the medical profession that has impeded a model of professional identity formation attentive to differences among regional origins, demographics, ethnicities, genders, and sexual orientations. As Cruess and his colleagues have recently put it, "The early history of modern professionalism in the Anglo-American world reveals that it was more exclusionary than inclusive, with women, nonwhites, and ethnic minorities having difficulty in finding a place" (Cruess et al. 1450). Writing about the self and others can help the future physician uncover her own prescriptive and descriptive assumptions, revealing points of entry into consciousness of difference in (professional) identity. But self-writing is only part of the process: for future practitioners to develop the fullest and richest empathic understanding and narrative competence, the necessary counterpart to self-writing is, of course, reading.

Many narrative theorists hold that reading about the lives of fictional or non-fictional others, analyzing the nuances of the personalities, thoughts, and ideologies those represented others display, and projecting ourselves into their subject positions enhances narrative competence and, in turn, "narrative empathy" (Keen, "Narrative Empathy").[16] Contentious though this position remains among contemporary narrative theorists and literary

[15] An early description of these activities at Columbia appears in Charon's "Narrative Medicine: Form, Function, and Ethics."

[16] In 2004, Maura Spiegel and Rita Charon edited a special issue of *Literature and Medicine* concerned with the relationship between empathic connections and medical knowledge and care ("Editors' Preface:

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critics alike,[17] I tend to agree with its premises; moreover, I would argue that those who have had less lifetime exposure to narrative theory and practices, such as conscientious physicians, are especially well positioned to benefit from the knowledge and cognitive comportment engendered by reading or viewing fictional narratives. In her early formulation of the concept of narrative empathy, Suzanne Keen observed some of the potential outcomes of a "very specific, limited version of empathy located in the neural substrate [that] meets in the contemporary moment a more broadly . . . defined . . . sense of empathy as the feeling precursor to and prerequisite for liberal aspirations to greater humanitarianism": "changed attitudes, improved motives, and better care and justice" ("Narrative Empathy" 208). "[I]mproved motives, and better care" are the key characteristics upon which the value of narrative approaches to medical education rests, and their dependence upon self-knowledge ought not to be underestimated. And it is here—at the intersection of "narrative medicine," "narrative empathy," and professional identity formation in a modern, multi-ethnic, culturally and sexually diverse, gender-conscious medical education arena—that postclassical narrative theories[18] take their crucial role in shaping a forward-looking medical education.

2. Narrative, Empathy, and Diversity: A Theoretical Perspective

Now well established, postclassical narratology continues to yield new theoretical, methodological, thematic, and interdisciplinary approaches to the study of narrative, and in their 2010 collection *Postclassical Narratology: Approaches and Analyses*, Jan Alber and Monika Fludernik identify "medical interviews" as a medial example of postclassical narrative inquiry (4). Where postclassical narratology is especially poignant for my purposes is in its implicit and explicit challenges to the problematic "in-group" characteristics that Keen describes in her discussion of empathic inaccuracy, and which resemble those of the historical Anglo-American medical professionalism that Cruess and his colleagues recount. Identity formation and empathy, which should be reciprocal influences in contemporary society, are thus susceptible to similar pitfalls derivative of bias; therefore, both depend

Narrative, Empathy, Proximity"), and Charon continues to advance the value of human connection and perspective taking in medical care. Additionally, a significant number of texts such as Rhonda J. Moore and James Hallenbeck's 2010 article "Narrative Empathy and How Dealing with Stories Helps: Creating a Space for Empathy in Culturally Diverse Care Settings" attest to the medical arena's commitment to the development and usefulness of empathy in treatment. From her 2006 article "A Theory of Narrative Empathy," through her 2007 *Empathy and the Novel*, to her recent assessment of narrative empathy through the lens of feminist narrative theory in "Intersectional Narratology in the Study of Narrative Empathy," Suzanne Keen continues to investigate the relationship between narrative and empathy.

[17] Consider, for instance, Catherine Gallagher's astute observations in *Nobody's Story* pertaining to the manner in which the reader tailors her image of the character to align with her own ideological and cultural dispositions, thus enabling her to more readily sympathize and empathize with her. In a different way, Keen acknowledges the same problem when she discusses empathy in a somewhat rhetorical sense, which I discuss below ("Narrative Empathy" 224; *Empathy and the Novel*, esp. 159-163). Keen also describes other pitfalls to which people in the ostensibly *active* mode of reading can fall prey: "Even the leap between reading and empathizing can fall short, impeded by inattention, indifference, or personal distress" ("Narrative Empathy" 213). Nevertheless, here as in *Empathy and the Novel*, Keen maintains that "fiction does disarm readers of some of the protective layers of cautious reasoning that may inhibit empathy in the real world" (213).

[18] See footnote 3.

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upon responsible, postclassical approaches to narrative competence, and thus, to the *teaching* of narrative competence. In her assessment of its pertinence to identity, Jarmila Mildorf describes a postclassical narrative approach thus: "Research on identity no longer assumes identity to be a monolithic conglomerate of essential features but rather a dynamic concept that is constantly and contextually (re)negotiated among interactants . . .. If identities are partially negotiated through narratives, the question arises in what ways narratives can offer scope for identity formation" (Mildorf 250). Mildorf then points out ways in which the storyteller might identify with various versions of projected selves, sometimes rendered as characters in personal narratives, whose ages, genders, socio-demographics, and ideologies might differ from those that the storyteller had previously embodied (or, more accurately, performed). "After all," writes Mildorf, citing Brockmeier and Harré, "'the exploratory and experimental options of narrative are inextricably fused with our fleeting reality itself,' . . . and for this reason 'one motive . . . of the study of narrative realities should be to investigate this opening-up quality of the discursive mind'" (251). Were medical educators attuned to nurturing the developmental aspects of identity fostered by a postclassical approach to narrative, and were they cautious to do so in a setting staged and directed by the various subject positions that a diverse student body such as those at McGill can voice,[19] empathic narrative identity formation would become a distinct possibility.

To better explain this, I'll first address the development of narrative empathy in a postclassical context. Keen's evolving scholarship on the relationship between empathy and narrative attends to poststructural challenges to "classical" narratology. In Keen's early estimation, bias, egocentrism, cultural background, or gender can breed what she refers to as "false empathy," or "empathic inaccuracy" (*Empathy* 136, 137). For Keen, this term denotes "a strong conviction of empathy that incorrectly identifies the feeling of a literary persona. Empathic inaccuracy occurs when a reader responds empathetically to a fictional character at cross-purposes with an author's intentions," and she suggests that such misreadings are unlikely to persist in real life: "Unlike in real-world, face-to-face circumstances, the novel-reading situation allows empathic inaccuracy to persist because neither author nor fictional character directly confutes it" (137). The question of confutation is paramount here. If we imagine the patient as the author of her own feelings and experiences from which the physician draws her readings, then in the clinical setting, the patient will not necessarily "confute" any empathic inaccuracies at which the physician arrives. First, the temporal limitations of doctor-patient exchanges could prohibit unpracticed or untrained Theory of Mind (ToM)[20] readers from moving far beyond the bias-generated,

[19] Here, I imagine "voicing" in the poststructural sense in which Garrett Stewart imagines it in *Reading Voices*. Stewart describes the "place of reading" as being in the "reading body[, the] somatic locus of soundless reception" in the brain (1). He further examines the place where we might read to ourselves as being a place of "displacement, a disenfranchisement of voice, a silencing," theorizing that where we read, "we listen" (2-11). Drawing on Barthes, he emphasizes the notion that "'*listening* is a psychological act'" (as opposed to hearing, which is merely physiological), and suggests that we take this concept a touch further. In so doing, we might say that it is a psychosomatic act. Because Barthes focuses on the musical text, Barthes's argument moves toward the space in which "*listening speaks*," which Stewart then inverts using the logic by which reading and listening, hearing and reading, are part of the same psychosomatic act to argue that *reading voices* (11).

[20] ToM is used in the cognitive sciences to denote that feature of human communication by which we have sustained life for centuries. "Theory of mind," observes Lisa Zunshine, "is a term used interchangeably with mind-reading, to describe our evolved cognitive capacity to explain observable behavior as caused by unobservable mental states" ("I Was Wrong" 1).

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quantitative readings they initially make. Second, should a patient perceive empathic inaccuracies in the physician's embodied or verbal signs, there is no guarantee that a patient will be inclined to correct her; indeed, patients are generally disinclined to do so, especially given the power dynamics of the exchange. Thus, I'm not convinced that empathic inaccuracy is any less likely in a clinical "real-world, face-to-face" encounter than it is in a fictional one. I will, then, proceed with an assumed alignment between the mindreading that occurs between reader and character and that which obtains between physician and patient. In this sense, much as each fictional reading encounter enables the critic to contribute to the body of criticism about the living text before her, the clinical encounter presents each physician with a new opportunity to contribute to the lifelong narrative of health the patient perpetually writes, making the most of her reading effort and improving her interpretation skills. Empathy researcher C. Daniel Batson's work is central to Keen's recent "disentanglement" of various forms of empathy, and for medical educators trained in the humanities, having a historicized understanding of these categories can be useful. To return to Keen, I will now discuss her more recent, postclassical iterations of narrative empathy.

Taking into account various approaches to the study of empathy by narrative theorists, cognitive scientists, and social and developmental psychologists, Keen's recent approaches to narrative and empathy are especially applicable to narrative competence training in contemporary medical education. Drawing on the feminist concept of intersectionality, which examines "'the relationships among multiple dimensions and modalities of social relations and subject formations'" (qtd. in Keen, "Intersectional" 125),[21] Keen attends to the "multiple competing axes of identity complicating any blanket assertions about what [the reader] contributes to the task of co-creating narratives through reading" ("Response" 108). Keen returns us to the question of identity, which applies both to the educator and to the budding physician. Of particular interest is the emphasis on the co-creation of stories central to the comprehension and development of clear patient narratives that give form to their experience. As the educator must remain pedagogically cognizant of her own "blanket assertions," so, too, must the clinician consider those aspects of her identity that could problematically influence the co-construction of patient narratives. Helping students and residents to consider the neuroscientific and cognitive relevance of empathy research, while also engaging them in the kinds of reading and writing activities that develop their narrative competence, can sensitize them to the nuances of reading either people or texts. Medical educators should thus continually challenge and restructure personal and professional identity in the light of those contingencies produced by their interactions with students of various ages, ethnicities, genders, etc., aligning their own, ongoing learning with that of their students. The more aware student and educator alike become of narratological nuances, of various nexuses of identity, and of how their own prescriptive and descriptive assumptions underlie their potentially deceptive biases, the more carefully they will read and the more expertly they will co-create.

3. From Theory to Practice: Engendering Empathic Communication Skills

My first foray into teaching narrative competence to medical practitioners occurred at McGill's International Masters for Health Leadership (IMHL) led by management theorist

[21] Sensitivity to these concerns also answers to recent calls pertaining to the Jefferson Scale and its ability to accommodate ethnicity and gender effects. See K. Berg et al.

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Henry Mintzberg. Designed to broaden and reshape healthcare providers' understanding of health and treatment in a global context, the program is comprised of faculty committed to the development of leadership, holistic approaches to wellness, health management, professionalism, clear and compassionate communications, and empathy. Of special concern at the IMHL, where ethnic, cultural, and ideological backgrounds vary considerably, is how best to foster a safe environment in which students feel free to express sometimes deeply personal and provocative narratives. Writing and sharing narratives about their own lives is critical here, and draws from the practices Charon championed. These practices encourage our students to move outside of their so-called comfort zones and toward the cognitive spaces occupied by their colleagues and imagined care recipients. Cultural difference, moreover, becomes specialty related at the residency level. To be sure, in my anecdotal experience, medical practitioners whose specialties depend upon qualitative, ideographic analyses derived from uncertain diagnostics and collaborative story-making over diachronic time have been initially more amenable to the concept of narrative medicine—and medical humanities more broadly—than, for instance, emergency physicians. However, when I taught the physicians and other health practitioners at the IMHL, I was delighted to find that, while those practitioners more dependent upon dialogue in clinical settings were initially among the keenest of listeners, time and persuasion helped to convince less likely allies of the value of this education.

After my first session with the cohort, several physicians expressed how valuable they found this help, the most vocal of whom was a pediatric oncologist. Unsurprisingly, pediatrics is an area that seems to be populated by practitioners with a relatively advanced narrative competence, so often resulting from triangulated (through parents) narrative explanations. Thus, that this particular physician was especially grateful for the education should, on the one hand, have come as no surprise. On the other hand, his appreciation suggests that even those we would expect to be most at home in the arena of empathic narrative comprehension discover with some exposure just how much there is to learn. There are certain benefits that no one seems to have difficulty understanding, the most obvious of which is a reduction in lawsuits brought against physicians. And in theory, physicians seem motivated by a closer connection to patients, a more adept, effective and efficient mode of history taking and diagnostics, and a resultant more efficient healthcare. But it is in those areas of medical practice that are, on balance, less dependent on interpersonal problem solving and collaborative story-making in which much of our work needs to be done.

Indeed, in these fields, such as surgery, the inoculation against empathy remains profound. As one cardiothoracic surgeon put it: "I'm the last stop. I have no one to call . . . . When they come to me, there are no alternatives. And 2% - 5% of them die." Then, with an expression at once anxious and resigned, he dropped: "I walk around with corpses in my mind every day." Given that this surgeon was the chief of cardiac surgery at a major U.S. hospital specializing in thoracic care, his observation and the expression that accompanied it continue to influence my curriculum-related decisions. Cordial and attentive, such audiences betray subtle resistance in their expressions: those very expressions that we ToM and active-listening researchers ought to read relatively well. Thus, a challenge of medical education rests in the cultures of various specialties, which give rise to significantly varied investments in diagnostics that derive from collaborative story-making.

On a different level, cultural difference inheres between medical students and residents, whose inoculation against empathy is virtually complete; once students have made it through medical school and have begun their residency programs, most have learned to

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protect themselves from the heartbreak of patient suffering and death, focusing instead on statistics, practical skills, and information consistent with nomothetic analyses and outcomes.[22] Rarely trained to enhance their receptivity to the idiosyncratic, many residents view the kind of work with which the medical humanities is preoccupied as less beneficial to their future practices than the acquisition of other forms of knowledge and information. Thus, cultural difference resides in three areas relevant to medical education: (1) educational level (undergraduate medical student, resident, faculty); (2) ethnic/cultural background, gender, and ideology; and (3) specialty specific cultures. As enriching as these various forms of cultural difference are, they can nevertheless contribute, along with the other factors I've described, to a certain degree of fragmentation. As Charon put it in her address to the Bronx VA a couple of years ago, "we are united in our fragmentation." But for many residents, their fragmentation is systemic and isolates them not only from their patients, but also from one another. In other words, though we may indeed be united in our fragmentation, we do not necessarily find that our fragmentation unites us. Thus, as humanities medical educators work to enhance the narrative competence and empathic accuracy of their students, they should turn the pedagogical challenges posed by cultural diversity into an asset. That is, medical educators should encourage their students to recognize their fellow colleagues—whose specialties often erect as much of a cultural barrier as regional distinctions—as human beings whose alterity is valuable, intriguing, enriching, and conducive to new forms of self-awareness and professional identity formation.

It is also useful for medical educators to toggle in their instruction between the "unidimensional, rational, value-neutral, computational, hierarchical and rigorous" study of conventional positivist medicine and the "affective, relational, complex, multifarious study" of human experience (Boudreau and Fuks 326). In my experience, medical students need increasingly to desire moments of cognition that challenge the mundane, such as typical, diachronic renderings of time. By troubling time and revealing its manifest nature, for instance, instructors can unveil commonalities between patients' and clinicians' phenomenological experience, allowing medical students to enjoy the kind of reflection that produces pleasure along the lines of Barthesian *jouissance*. These pleasurable moments of reflection, moreover, become more gripping—more interesting—precisely because they are uncanny. They need to practice navigating the active cognition that inheres in strangely familiar concepts such as manifest time, but then need to return to the familiar space of the practical—such as the time of appointments, scheduling time, time to completion—in which they feel comfortable and competent. Once medical students, residents, and/or physicians are engaged in troubling those less familiar aspects of their own and their patients' lived experiences, the real challenge presents itself: encouraging them to appreciate the finer nuances of narrative.

Having taught a highly diverse graduate and undergraduate student population about cognitive and affective empathy for many years, I have found that nurturing my own empathic disposition while enhancing my understanding of its theoretical and practical applications in various domains has been foundational to my work with medical students and physicians. University instructors trained in the humanities generally are—or at least ought to be—predisposed to a constant awareness, evaluation, and restructuring of their own professional identities and practices. Being a good ToM mind-reader is fundamental to taking a history, to recognizing when an interlocutor is "holding back," to distinguishing

[22] One group of sciences works by way of positing general laws and understanding its objects as examples of such general laws (nomothetic). Another group of sciences aims at producing illuminating descriptions of irreducibly individual and unrepeatable occurrences (idiographic) (Windelband).

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between a parent's irrational fears and a description of a child's actual health concern, to communicating effectively with other specialists treating one's own patient, and other critical exchanges. Above all for the purposes of pedagogy, ToM is critical to guiding a culturally diverse classroom populated by students ranging from those who relish an audience to those disinclined to speak, as well as to students whose learning is imperiled by distracting biases. With these conditions in mind, my discussions and instruction with physicians has given rise to a pedagogical approach involving the very empathic, rhetorical narrative competencies I work to engender: the first task of medical educators is to use our rhetorical skills, together with our active listening skills, to convince unlikely audiences of the value of that part of ancient medical praxis called *humanitas*. This means embodying and, indeed, exemplifying, the kinds of empathic, effective listeners and communicators we hope our medical students and residents will become. They need to see first-hand, and reflect later upon, the value that an open, curious, theoretically complex, and philosophically rich disposition brings to their experience of learning. Along the lines elucidated by Kenneth Burke, students essentially need to want to be "like" versions of their educators that would make good, empathetic physicians (Burke 203). If we don't achieve that, we will have great difficulty achieving much else.

When I began developing a curriculum in Postgraduate Medical Education at the Faculty of Medicine, I did so with an acute awareness that, while my theoretical training, literary criticism, scholarly research, and pedagogical experience had given rise to this opportunity, my evidentiary knowledge about what would be effective in the classroom was largely idiosyncratic and anecdotal, reflecting the experiences of most medical humanities educators. Fortunately, this uncertain space is familiar to literary scholars. For while medical education has, since its cleaving from the human sciences, invested largely in nomothetic approaches and outcomes, those whose scholarly lives have always been ideographically driven are, by and large, conditioned to inhabit the space of the profoundly unknowable. Moreover, we are accustomed to inviting our students to join us there, fostering a Socratic and mutually beneficial education that depends upon reciprocal learning, and requires of us that we embody the empathic collaborators our medical students will emulate in practice. To return to the chief of heart surgery I mention above, when I told him what I do, he said, "Oh I'm not a renaissance man. I don't understand all that stuff." On the one hand, he was no doubt being generous and humble, but on the other hand, many physicians whom I've encountered purport to feel this way, and reminding them that they *are* in fact "renaissance men and women" is crucial. As Boudreau and Fuks put it, "The humanities are inseparable from medical practice as cognate disciplines and not specifically because they may inculcate humaneness" (328).

Finally, to appropriate Keen, "It will be interesting to discover whether diverse [medical students', residents', and physicians'] improved narrative competence, in the wide range of functions involved in narrative, leads to an *automaticity* of other-oriented perspective-taking that could have the power to override implicit biases or even permanently alter these readers' attitudes" ("Intersectional" 108). Those discoveries, at least for the time being, will be unique, idiosyncratic, and largely limited to the schools and contexts in which they are occurring. At this stage, the task of the narrative theorist-medical educator is to foster an environment that surfaces and unravels—to whatever extent possible—implicit bias, making space for reciprocally influential, multi-cultural, multi-ethnic, gender-neutral dialogical learning.

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