Teaching Literature during a Pandemic-Induced Empathy Deficit

A Narrative Medicine Approach to Pedagogy

Tyler Jean Dukes

Novelist James Baldwin (1963: 88) said in an interview with *Life Magazine*, "You think your pain and your heartbreak are unprecedented in the history of the world, but then you read." Books teach us that our torments are not solitary and our human suffering is "the very thin[g] that connect[s] [us]" to other people and helps us empathize with them (88). Or, to borrow terminology from physician-scholar Sayantani DasGupta (2008: 980), literature gives the reader an "entry point" into another person's suffering. Well, at least it did pre-pandemic. Shutdowns and social distancing have forced people to make "wholesale changes" to their everyday lives, from the way we work to the way we connect with friends and family, attend religious services, shop, celebrate, receive medical care, and teach (Deane, Parker, and Gramlich 2021). The list goes on, but these changes do not come without growing pains.

Researchers would say the pandemic has pushed us to our empathetic limit. "Higher levels of stress, coupled with the lack of opportunities to connect with others," has lowered our ability to empathize (Shah 2021). In other words, COVID-19 has created what some deem a global "empathy deficit." According to clinical psychologists, prolonged physical and mental exhaustion can cause a decrease in the reward system of our brains that feels fulfillment when helping others (Scully 2021). Studies have shown that short-term stress can promote helping tendencies (Linley and Joseph 2004),

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especially in "direct, face-to-face helping situations" such as dire emergencies (McGinley et al. 2010: 47). Chronic stress—like that experienced during the pandemic—can lead to fewer altruistic prosocial tendencies (47). The brain can see altruistic acts as costly sacrifices that could compromise personal stability (47). As a result, we may feel an overall dread when considering caring for others (Scully 2021).

A narrative medicine approach to pedagogy would say that, in the face of the pandemic's collective trauma, it is our responsibility as educators to "witness our students' lives"—which are bigger and messier than ever—with a presence of receptivity and transparency (DasGupta 2020). Narrative medicine encourages us to model a radical vulnerability when engaging with others. With this in mind, our pedagogy can foster a sense of co-intentionality between students and instructors, supporting sustained empathetic growth for both parties. Education, under a narrative medicine–informed values system, has the potential to be a "life-affirming experience" through which both students and instructors "discover their humanity and connectedness to each other" (Damianidou and Phtiaka 2016: 9). When the "channels of communication are open and secure," and students and teachers trust that they can share their experiences, their analyses, and their life stories without inhospitable criticism, the classroom can blossom into an empathy-building environment (9).

The tricky question is, how do we proceed during the pandemic if both students and instructors are operating from an empathy deficit? Is there a way to embody a narrative medicine pedagogy within our literature courses that mitigates the effects of our current empathetic deficiencies? Can we do so in a manner that does not create a parasitic burden on our instructors? And what would happen if we suffused our literature courses with the values of narrative medicine—a story-telling and story-receiving practice from the medical humanities—to create an empathetic, courageous, and nourishing student-teacher relationship during COVID-19 and beyond?

Pandemic-Induced Empathy Deficits

The "empathy deficit" is not a new phenomenon. Pandemics have historically driven people apart. Staying away from your neighbor during a pandemic is not seen as rude or disruptive to social norms but rather as a survival mechanism. Giovanni Boccaccio wrote about this dissolution of mutual human interest in the *Decameron*, describing how citizens in plague-ridden 1340s Florence "held aloof, and never met" to protect themselves from infection from others (Brooks 2020). Daniel Defoe ([1665] 2008: 69) likewise wrote

about a reduction of empathy in his *A Journal of the Plague Year* in 1665 ("they had no room to pity the distress of others"), as did Katherine Anne Porter (1939: 232) in her *Pale Horse, Pale Rider*, a novella describing the 1918 Spanish Flu pandemic ("They must come for her now, or I'll put her out on the sidewalk . . . I tell you, this is a plague, a plague, my God"). In these works of fiction and others, the authors often treat plagues as the corporeal manifestation of divine punishment, but even more so, as the harbingers of alienation and self-preservation for the individual.

People may indeed unite at the beginning of a pandemic against Public Enemy No. 1, the virus. For example, in Defoe's ([1665] 2008: 60) *Journal of the Plague Year*, inhabitants of adjacent villages unaffected by the bubonic plague would pity their suffering neighbors and "carry them food and set it at a distance." In the first year of the COVID-19 pandemic, we saw people similarly helping en masse. Volunteers set up testing sites. People offered to go shopping for those friends and family members at risk for severe disease side effects. Everyone from politicians to celebrities to third graders sent virtual messages of hope and positivity. But over time, the drive toward self-preservation can usurp our higher moral selves. Thousands of years ago, the stoic Hierocles developed the concept of *oikeiôsis* to describe our impulse toward self-preservation. The premise of *oikeiôsis* is that our "empathy and affinity for others declines by [their] proximity to our lives" (Fisher 2020). Hierocles illustrated this idea with what he called "Hierocles' Circles," or what people today sometimes refer to as "empathy circles" (Hanselman 2020). Imagine a series of concentric circles, like a dartboard, where the bull's-eye corresponds to the self, the next circle to one's family, the third to one's friends, the fourth circle to one's fellow citizens, and the last to humankind. In the best of circumstances, the stoic's goal was for us to "always seek to draw further circles toward ourselves," at the center, treating our family as we would ourselves, friends as we would our family, and so on. But in times of scarcity or plague, sometimes all we can muster is a protection of the innermost circle or circles—that of us and, if we are lucky—that of our immediate family.

Evolutionary psychologists have, to a degree, confirmed the stoics' hypothesis, identifying "ancestral" human motives that complement Hierocles's circles (Griskevicius and Kenrick 2013: 372). Evolutionarily, as humans, we first evade physical harm. Second, we avoid disease. Only then can we make friends, attain status, acquire a mate, keep a mate, care for a growing family, and so forth (372). During the COVID-19 outbreak, the desire to preserve the self (by avoiding disease) manifested as individuals implementing

periods of "self-isolation," the formation of "pandemic pods," and so on. But as we physically distanced ourselves from others, we got further away from witnessing in person the lived experiences of humans located in our second, third, fourth, and fifth empathy circles. Suddenly, most of our interactions with friends, family, fellow citizens, and other humans was relegated to virtual communication. Studies confirm the shortcomings of virtual empathy. The "lack of non-verbal cues in the online world" leads to "overall lower levels of virtual empathy compared [to] real world" empathy (Carrier et al. 2015: 39). Thus, our human impulse for self-preservation (which led to reductions in face-to-face interactions) explains at least in part, our international empathy deficit, but cannot account for it all.

Another partial explanation for our current empathy problem is our inability to look away from terror and its aftermath. Clinical psychologists say that witnessing a fatal traffic incident in person, and reading a report about a fatal traffic incident, can have similar effects on the parts of the brain that assess threats (Page 2017). COVID-19 required us to assess threats both in-person and digitally. For example, in the summer of 2020—in addition to all the risk assessment I was doing in person via masking, social distancing, and avoidance—I remember compulsively checking the *New York Times*' webpage that updated COVID-19 case counts and fatalities and looking at my university's COVID-19 dashboard for current cases and hospitalizations. I could not peel myself away. The COVID-19 pandemic created a "sudden need for ordinary people," like me, "to find and process large amounts of complicated and rapidly evolving information" (Deane, Parker, and Gramlich 2021). In the first year of the pandemic, especially, it was as if we were all constantly on high alert; filtering through both real and reported threats to assess our level of risk.

The exigent checking of virtual news sources for emergencies is not a behavior exclusive to the pandemic, but it certainly ramped up in frequency for many individuals in 2020. People often engaged in doomscrolling behaviors when they were afraid and wanted answers. *Doomscrolling* refers to the obsession of "trawling through feeds without pause, no matter how bad the news is" (Klein 2021). Instead of feeling satisfied and safe after going down a "scroll hole," however, people ended up on a Ferris wheel of endless trauma consumption. So many exhibited this behavior in 2020 that officials added the word to the *Oxford English Dictionary*. In many ways, we can view doomscrolling as a strategy-gathering approach rooted in evolutionary survival. Others might say this seemingly mindless behavior is thinly veiled morbid fascination. Still, others could blame doomscrolling on social media plat-

forms that incentivize addictive behavior with their algorithms (McCluskey 2022). Whatever the cause, consistent exposure to suffering "without a working plan to manage the consequences of th[at] trauma" can lead to emotional burnout (Scully 2021).

Personally, in the past twenty-four months as a PhD candidate and graduate instructor, I have withstood the loss of my mother, being ill with COVID-19, "long COVID" for months after, and a continuous flip-flopping between online and in-person instruction. In many ways, I consider myself lucky. My mental health has survived because I have an operational plan I have used in the past as a childbirth doula to manage my own physical and emotional well-being before witnessing and engaging with others. But I would be lying if I did not say that, at times during the pandemic, my "working plan" to self-soothe and self-regulate went out the window. Like others, I oscillated between starry-eyed optimism and gut-wrenching loss, between resentment and absolute numbness. I still struggle occasionally with lower empathy reserves, as do many of my colleagues and students. I share my story here not to call attention to my suffering—as it is one story among millions during this pandemic—but rather to model the "co-intentionality" built into a narrative medicine pedagogy, wherein the telling and witnessing of stories leads to a greater understanding of the "Other . . . 'the face we cannot know but to which we are responsible'" (DasGupta 2008: 980).

Healer-Scholar

My investment in the field of narrative medicine came about directly from my doctoral qualifying exams from 2018 to 2019 (with a focus list on the medical humanities) and indirectly from a lifelong interest in narrative catharsis. As I mentioned, I am a trained childbirth doula, and, as part of my training, my mentors taught me the central importance of storytelling. Scholars have shown that a birthing person's narrative of their labor is intimately tied to their "identity formation" (Carson et al. 2016: 817). The act of postpartum narration, in particular, can allow a new parent to "assimilate their memories" of a life-changing event (childbirth) into their current sense of self; this is especially critical if the experience did not go as planned (Kay et al. 2017: 2). Leslie Kay and colleagues (2017: 2) write, "Articulating [what can be a traumatic] experience into a story gives it structure; once the experience has a structure, there is potential for meaning to be determined and emotional responses considered."

As a doula, the majority of postpartum visits involve me listening to clients tell their birth stories. They are the storytellers. Their first-person

perspective of events is embodied and absolutely non-replicable. As the story-receiver in these encounters, I am responsible for listening and participating with profound intention. I cannot project my own opinions or recollections of their birth onto them, because that may negatively interfere with their perception of events. My goals are to listen deeply, reflect back an attitude of radical acceptance, and offer additional support or resources when appropriate.

This is all to say that my experience as a doula—which calls for me to put receptivity and cointentionality into action—primed me to adopt a narrative medicine-informed pedagogy during the pandemic. Through this adoption, I invited literature students to become both storytellers and story-receivers. The result was students who felt more dexterous in structuring their COVID-19 experiences into something that made sense. Before describing the details of how this led to empathy-building, however, let me take a step back and provide a brief overview of precisely what narrative medicine is and where it originated.

Narrative Medicine

Narrative medicine is a medical practice established by Rita Charon and her colleagues at Columbia University in the early 2000s. It was developed for and by physicians, aiming to help doctors prioritize their patients' stories as a powerful healing modality. Narrative medicine arose from a dire need to insert humanity back into modern medical practice. Our current US medical system is rife with systemic problems. Time scarcity is one of these challenges because it decenters the human-to-human interactions between physicians and patients. During the average work day, doctors spend 22.2 percent more time doing administrative tasks and paperwork than they do speaking with their patients (Sinsky et al. 2016: 1). Therefore, when interacting with patients, physicians may only be looking for physiologic manifestations of illness that are quickly identifiable and can "dismiss other patient concerns as small talk" (Bohanon 2019). This type of rushed clinical environment is not set up for empathy-building.

What's more, some researchers have suggested that physicians can detach from their empathetic reserves before they become working doctors. One study shows that during their training, medical students demonstrate a significant decrease in empathy as they progress through their curricula and must cope with the stress and burnout of the health-care industry (Neumann et al. 2011: 1001). Additionally, they must navigate the unrealistic expectation that physicians maintain stoic neutrality "through[out] their day-to-day lives as healers" to prevent themselves from "feel[ing] too much" and becoming "[worn]

out" and "dysfunctional" (Majd 2015). Hopeful counterstudies, however, make clear that medical programs that teach narrative medicine to students can improve their students' "reflective capacity and empathy" (Daryazadeh et al. 2020: 1) and reduce physician burnout (Winkel et al. 2016: 27S). In other words, when narrative medicine is taught in tandem with a traditional biomedical curriculum, medical students and physicians can better "recognize the plights of their patients," "extend empathy toward those who suffer," and "join honestly and courageously with patients in their illnesses" (Charon 2001: 1897).

Shannon R. Wooden, Maura Spiegel, and Sayantani DasGupta (2010: 471) predicted that narrative medicine would become an "emerging paradigm" that would "transform" medical education. Broadly speaking, they were correct. Institutions like Baylor College of Medicine (in 2016), the University of Southern California (in 2020), and the University of Arizona College of Medicine (in 2015) have all added a graduate program, certificate, or summer-long course in narrative medicine. With the opening of a new medical school, my own institution has pledged itself to training Empathetic Scholars® (*TCU Burnett School of Medicine*) using the tenets of narrative medicine as a guide. It is safe to say that the paradigm is no longer emerging in medical education but has arrived.

The pandemic has only solidified how desperately our country needs reflective spaces as physicians and patients digest their pandemic-related traumas. The *Los Angeles Times* published an op-ed in the summer of 2020 describing how medical professionals were using narrative medicine to cope (Stephens 2020). Due to strict hospital protocol early in the pandemic, worried family members could not visit dying loved ones in the intensive care unit. Frontline health-care workers counseled these families through the process, and many of them encouraged the families to share stories as a way to cope. Likewise, academic journals like *Survive and Thrive: A Journal for Medical Humanities and Narrative as Medicine*, as well as *Intima: A Journal of Narrative Medicine*, have encouraged health-care workers, academics, and laypeople to reflect on their experiences during the pandemic and share their stories involving clinical encounters. This scholarly interest has further concretized narrative medicine as a valuable clinical and interdisciplinary framework fit to counteract the empathetic nosedive during a public health emergency.

A Narrative Medicine Approach to Literature

It is no wonder, then, that scholars outside of the medical field have taken notice of narrative medicine. A chorus of humanities instructors—including psychology, economics, and law—have somewhat "recently realized the

importance of narrative knowledge" (Charon 2001: 1898). Since the mid-1990s, the "affective turn" in the social sciences and humanities has underscored the value of narrative knowledge. And as a result, literary scholars have undertaken a "comprehensive effort to rethink the source and operations of human emotion" (Armstrong 2014: 442). Affective theory is now part and parcel of literary studies. Pleasure and pain have buoyed to the top of this affective discourse, as has empathy. University and college professors have also prioritized empathy in their curricula. There are countless courses centralizing empathy: University of California, Berkeley, offered a Literature, Empathy, and Human Rights course; Clemson University offered a course titled Literature as Catalyst for Empathy; and Eckerd College, a Storytelling and the Art of Empathy.

One of the reasons educational institutions have put so much emphasis on literary studies is that research has shown that reading fiction increases one's cognitive, affective, and real-world empathy (Stansfield and Bunce 2014; Bal and Veltkamp 2013). Fiction readers can not only understand another person's worldview as a result of reading fiction but are also more likely to share in another person's emotions and participate in real-world "helping tasks" like volunteering (Bal and Veltkamp 2013: 10). Unlike nonfiction readers, who show little to no increase in empathy after reading a nonfiction text, fiction readers can "transport" themselves through the "detailed moment-by-moment description" of a protagonist's inner thoughts and feelings (Stansfield and Bunce 2014: 2). In other words, they can get "lost" in a book. This transportive process leads to greater feelings of connection and improved understanding of action and consequence; additionally, it has been shown to reduce instances of prejudice (Damianidou and Phtiaka 2016: 4).

But what happens to students' empathetic capacity when they read fiction during a pandemic-induced empathy deficit? Does empathy still increase when reading? Or does it decrease? Future studies on reading fiction during periods of chronic stress will need to address these questions. What I can offer now, however, are notes from a fully synchronous online course I taught in the fall of 2020 that, anecdotally, built student and instructor empathy. It did so by emboldening both instructors and students to become storytellers and story-receivers in the classroom and beyond.

Introduction to Fiction: Narrative Medicine

To illustrate how literature courses can grow student and instructor empathy—even during a global empathy deficit—I want to discuss an introductory literature course I designed and offered called Introduction to Fiction: Narra-

tive Medicine. Like many introductory literature courses, it guided students through various fictional texts from diverse authors, historical periods, and geographical areas. However, the texts for the reading all included the motifs of health and illness.

Introduction to Fiction: Narrative Medicine was interdisciplinary by design, allowing me to combine critical concepts from the medical humanities, disability studies, psychology, the history of medicine, philosophy, and literary studies through the framework of narrative medicine. Imperatively, I wanted the course to draw upon existing empathy and literature courses while adding in the additional narrative medicine components of reflective writing, co-receptivity, and the practices of storytelling and story-receiving. The guiding questions for the course were: How can fiction help us understand illness and wellness? How does sharing one's own stories about disease and treatment help shape our identities? What role can narrative play in the physician's and the patient's attempts to find meaning or coherence when faced with illness? A complete overview of the course lies beyond the scope of this brief report. However, I want to highlight the Reflective Writing Responses (RWRs). These were the most important activity students engaged with throughout the semester because they operationalized the concepts of narrative medicine while encouraging critical thinking and empathy-building. Students completed one RWR per class. They took thirty minutes total: fifteen minutes for individual writing and fifteen for discussion.

I adopted the Reflection Evaluation for Learners Enhanced Competencies Tool (REFLECT) to assess RWRs. The REFLECT rubric is an empirically developed and tested competency tool used in medical education (Wald et al. 2012). Reliably, this rubric can assess "students' reflective levels and assist in the process of providing individualized written feedback to guide reflective capacity promotion" (41). It can be tricky assessing reflective writing in English courses because it is subjective to some degree. I wanted to adopt a clearly defined rubric like REFLECT that could reliably promote "reflective capacity" (41). My revised version of the REFLECT rubric had five sections: (1) "Writing Spectrum," (2) "Description of Issue or Conflict," (3) "Attending to Emotions," (4) "Analysis and Meaning Making," and (5) "Attention to Assignment." Each section was weighted evenly to communicate to students that, in this course, identifying your emotions was equally as important as analyzing the text; having a broad writing spectrum was as critical as your attention to the assignment; and so forth. Placing empathy-building alongside critical thinking in the students' RWRs was one of the more successful components of the course.

To further illustrate the progression of an RWR, below is the heading, a sample prompt, and a student response.

Reflective writing is an essential tool we utilize to become better writers and analysts, but more importantly, human beings. The Reflective Writing Responses are intended to help us:

- Record our evolving thought processes
- Explore our assumptions, values, beliefs, and biases
- Formulate new opinions and perspectives
- Examine challenges, dilemmas, or conflicts
- Recognize and acknowledge our emotions
- Create meaning for ourselves
- Develop a sense of understanding, or empathy, for ourselves and others

RWR #13 Prompt

When Adam and Miranda discuss the disease circulating in their community, Adam suggests that he and Miranda should be "strong-minded and not have any of it" (Porter 1939: 200). Implicit in this statement is Adam's belief that only "weak-minded people" become sick with the disease. Adam's reaction is not uncommon. Throughout history, people have assigned moral significations to health and illness. The belief is that healthy people are morally good or strong, and ill people are morally bad or weak. Think about your own experiences with the coronavirus pandemic. Have you encountered any rhetoric like Adam's that assigns moral value to either healthy or ill people? What are your thoughts about this type of morally loaded rhetoric? How does it make you feel about the person/people in question? About yourself?

Student Response (John)

When reading this prompt, I immediately thought of an instance that occurred about a month ago that mirrors Adam's rhetoric that assigns moral value to either healthy or ill persons. My entire friend group, except for me, came into contact with a student who tested positive for COVID-19, so they all had to quarantine but I did not. I made jokes to them about how I was the superior and strongest friend, including one saying that "only side characters have to quarantine," implying that I was the main character; I would like to note that these were purely jokes said toward my close friends and meant absolutely nothing, which my friends knew. Ironically, 7 hours after I made my side-character joke, I was in the hospital receiving news that I tested positive for COVID-19. I was shocked, and a wave of fear came over me because I knew I would have to go into isolation, causing me to face my greatest fear of being distanced from those I love. To this date, I am the only one in my friend

group who has actually contracted the virus. I believe I deserved what I received because I was not doing my best to take care of my friends when they were worried about the virus; it was not alright for me to poke fun when they were developing new worries, fears, and a sense of loneliness. I made these comments as a joke and did not mean what I was saying, so my thoughts about this type of morally-loaded rhetoric is that it is completely incorrect. Anyone is capable of contracting COVID-19, so the belief that only "weak-minded people" become sick with the disease is pure nonsense to me; no one is actually the "superior and strongest friend" and no one is the side or main character in a friend group. I was the least likely of my friends to contract COVID-19 when I did, but I was the only one to get it. Does this mean I am the weakest friend? I do not believe so and neither do my friends. When Adam makes this claim and makes this rhetoric, it makes him lose credibility to me. I grew up in an environment that encouraged acting tough and simply "sucking it up" when I got injured, so I can relate to his perspective and see where he is coming from; however, the fact that he believes this in the environment he is in makes me think of him as close-minded. Because I grew up in an environment that is strongly related to Adam's rhetoric, this claim of only "weak-minded people" become sick creates a sense of nostalgia and growth in myself. Nostalgia because it brings back images of little-league baseball and soccer, where I got injured a lot, and growth because I no longer believe that only the weak get hurt.

In his thoughtful response, John explores the RWR's key concept of morality and health ("I made jokes to them about how I was the superior and stronger friend [because I did not have to quarantine]"). Next, he relates his experience to the character Adam from *Pale Horse, Pale Rider* ("When Adam makes this claim and [uses] this rhetoric, it makes him lose credibility to me"). Throughout, John identifies specific emotions that he and his friends felt during this experience ("shocked," "worried," "fearful," "lonely"). He also expresses remorse for not being more compassionate towards his friends ("I was not doing my best to take care of my friends"). And then, he ends with a reflection of a time when he felt like Adam ("I grew up in an environment that encouraged acting tough and simply 'sucking it up' when I got injured, so I can relate to his perspective and see where he is coming from").

This response is a clear example of a student moving beyond "checking off" the assignment's requirements to building empathy and understanding of himself and others through critical self-reflection. As John works through the RWR prompt, we see him becoming a more "ethical subject" (Hanselman 2020).

Considerations

Many students initially struggled with this level of reflective writing. In previous English classes, students voiced that they had written from the first-person perspective but had not conducted this type of critical self-reflection. As expected, there were days when students encountered a degree of resistance to sharing about their lives and witnessing the lives of others. It requires considerable vulnerability for someone to examine a piece of themselves so thoroughly, before stitching that piece into the broader human fabric of fiction and society.

There are emotional and psychological risks when asking reflective questions with such gravity. Pulling from my work as a doula, early in the semester I advised students to draft their own operational plans to manage their emotional well-being and to self-soothe if discussions in class were too intense for them that day. I also modeled this self-awareness through my own behavior. If a topic maxed out my emotional capacity, I let students know. This only happened once over the course of the semester. But by modeling self-compassion—and communicating with others when I needed a break—it permitted students to approach their affective responses with a similar curiosity and care. That said, I also regularly reminded students throughout the semester of the Counseling and Mental Health Center and COVID-19 relief programs available through our university. Since I am not a therapist or psychologist, it was vital for me to clarify my role and remind students that reading fiction and writing reflectively can elicit catharsis, but that mental health experts are the ones trained to offer specialized and sustained support.

On a separate remark, I would be remiss not to mention that women, particularly BIPOC women, often do more emotional labor in higher education, as do many adjuncts, graduate students, and untenured lecturers. In a pandemic-induced empathy crisis, it is poignant to note that institutions and faculty members predominately depend on these marginalized (and frequently, underpaid) groups of individuals to dig us out (Berheide, Carpenter, and Cotter 2022: 441)—with or without their consent to the emotional labor that empathy-building entails. There should be no expectation in place for women and/or BIPOC to be solely responsible for this work. Instead, faculty members across the board should contribute to building empathetic students. Additionally, there needs to be consideration of how student-directed emotional labor is unequally distributed across the university, with "liberal arts and science" faculty shouldering more emotional labor than "pre-professional departments" (451).

What we need is tenured faculty—and those not part of marginalized groups—to implement empathy-building practices like reflective writing into their curricula. This can be extremely simple and does not necessarily have to involve fully adopting a narrative medicine-based pedagogy, or only including fictional texts that address the motifs of illness and health. It could be as small as a weekly or monthly reflective writing exercise that encourages students to become storytellers and to critically reflect on their relationship with themselves, their peers, and the characters in the text. Small reflective writing exercises such as these have been proven to be "therapeutic" in "reduc[ing] burnout and restor[ing] [the] voice" of the storyteller (Murphy, Franz, and Schlaerth 2018: 1). They can also help "regenerat[e] enthusiasm and creativity"—a needed benefit as the pandemic rages on and we all collectively process the magnitude of our experiences over the past few years.

Conclusion

Since its inception, various health-care providers—doctors, nurses, therapists, and health activists—have come together under the umbrella of narrative medicine to "reimagine health care based on trust and trustworthiness, humility, and mutual recognition" (Columbia University 2019). Narrative medicine as a clinical practice encourages health-care providers to switch from asking, "How can I treat this disease?" to "How can I help my patient?" (Krisberg 2017). It shifts the physician's focus from the "need to problem-solve to the need to understand" (Zaharias 2018: 176). As a result, "the patient-doctor relationship is strengthened, and the patient's needs and concerns are addressed more effectively and with improved health outcomes" (176).

If we apply the ethos of narrative medicine to the humanities and, more specifically, to literature courses, we might shift from asking, "How can I teach this student as much as possible in the time allotted?" to "How can I help this student?" "Is there a student-centered pedagogy that intentionally builds empathetic citizens?" Drawing from the outcomes of my pedagogical experience teaching Introduction to Fiction: Narrative Medicine in 2020, I know we can mitigate some of the deleterious effects of our current international empathy deficit by bringing the practical tenets of narrative medicine—primarily, reflective writing, co-receptivity, and the practices of storytelling and story receiving—into the literature classroom. The result is a courageous and nourishing student–teacher relationship built on the healing power of stories and empathetic reciprocity.

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