



Empathy and Virtuosity: Reinventing Narrative Medicine and Medical EducationM

Dr. V. Ponnulexmi¹, Mr. V. R. Rojar Benz²

¹Associate Professor, Department of English, St. Joseph University, Tamil Nadu, India

²Research Scholar, Department of English, St. Joseph University, Tamil Nadu, India.

Abstract- Empathy is a fundamental value in medicine and medical education and is often regarded as an antidote to the widespread perception of dehumanization in contemporary clinical practice. However, the concept of empathy—along with related notions such as attention—remains ambiguously defined and inconsistently theorised. Current approaches tend to emphasise the understanding and measurement of empathy primarily for remedial or instrumental purposes. This article challenges dominant discourses on empathy in medical education by arguing that the privileging of competencies fosters a reductive and overly instrumental approach to its teaching and learning. Drawing on literary narratives, particularly Gabriel Weston’s *Dirty Work*, Wilfred Owen’s poetry, and classical texts such as Homer’s *Iliad*, the study proposes that the ancient concept of ‘pity’ provides a richer and more integrated framework for understanding interpersonal care. Situating empathy within broader debates on narrative medicine, professionalism, virtue ethics, and aesthetics, the article reconceptualises medical communication not merely as a measurable competency but as a form of embodied virtuosity. Ultimately, it calls for an educational paradigm shift—from the quantification of empathy toward the cultivation of ethical responsiveness through narrative engagement, touch, vulnerability, and the aesthetic formation of the medical self.

Keywords- Empathy, Medical Education, Medical Humanities, Narrative Medicine, Pity, Professionalism, Virtuosity.

I. Introduction

Empathy is the main discourse of contemporary medical education. It is a wide aspect for patient-centred care, ethical professionalism, and humane clinical practise. Future doctors demonstrate empathy in their technical competence because of the changes in accreditation bodies, curriculum design, and educational policy. Empathy is both universally recognised and deeply contested. Despite decades of research, there is no settled agreement on what empathy is, how it operates, or whether it can be reliably taught and measured. This article not only says the lack of empathy but also speaks to the flaw of understanding. By revisiting literary, philosophical, and historical sources, especially in the medical humanities, the emphasis is on empathy, which redefines the ancient note of pity. It can be measured by a psychological attribute.

Wilfred Owen’s poem *Insensitivity* provides an insight into medical training. The poem was written from the trenches of the First World War. It reflects the emotional and survival face of the soldiers. The poet suggests that the soldiers make themselves “immune to pity” to endure. Yet this immunity threatens their humanity.



Students are repeatedly exposed to pain, illness, and death, often within a hierarchical and emotionally harsh training environment, because of the dilemma in medical education. As Gabriel Weston's *Dirty Work* illustrates, this exposure can result in emotional disengagement rather than resilience. Weston's depiction of Mr. Hanforth, the consultant surgeon who performs a painful procedure with brisk efficiency and minimal regard to the patient's distress, exemplifies what passes for professionalism but falls short of empathy.

Weston contrasts this scene with his later epiphany as a junior doctor, an experience rooted not in clinical detachment but in visceral discomfort, memory, and touch. Her recognition of the patient's humanity is catalyzed not by abstract ethical reasoning but by an ordinary object—a hairbrush—that connects the patient to her own familial memories. It is said that empathy emerges not from emotional distance but from ethically charged proximity. Politeness or sympathy causes confusion in medical practise. As a medical student, politeness and courtesy are without compassion. Sympathy, defined as “feeling for another, does not require relational engagement.

Empathy is involved in “feeling with” the patient. In clinical settings, it is perceived as dangerous, threatening emotional control, professional authority, and objectivity. Consequently, students are subtly taught to manage emotions by suppressing them, reinforcing a culture of insensibility masquerading as clinical efficiency. This is reinforced by biomedical paradigms that privilege diagnosis, technology, and disease over personhood. The patient becomes a case, a site of pathology, rather than a relational subject. Emotional distancing thus becomes a failure, but a survival strategy. Empathy is measured by psychometric instruments, such as the Jefferson Scale of Physician Empathy (JPE), which exemplify the epistemological limits of medicalised empathy.

The scale primarily defines cognitive capacity, especially in understanding a patient's perspective and communicating that understanding. The affective domain is sympathy, which is implicitly framed as less professional. By excluding emotional identification, empathy is rendered safe, manageable, and measurable; it is also hollow, as said in Weston's narrative, as a patient needs sympathy, the affective, embodied, and ethical dimensions of care. Moreover, self-report measures are vulnerable to bias and performativity. Students may learn how to appear empathetic without genuinely engaging.

Empathy has long been regarded as a foundational value in medicine, integral to ethical practice, patient trust, and humane care. Recent research suggests that empathy among medical students has steadily declined, mirroring broader cultural shifts. Scholars such as Konrath, Twenge, and their collaborators have documented a measurable reduction in empathic concern alongside a significant rise in narcissistic traits among younger generations (Konrath et al., 2011; Twenge, 2014). Parallel to these psychological trends is a noticeable decline in reading for pleasure, particularly literary fiction, among young adults.

This conjunction is not coincidental. Psychological studies increasingly demonstrate that engagement with literary fiction enhances theory of mind, emotional intelligence,



and the capacity to imagine the inner lives of others. Fiction, as Kidd and Castano argue, “temporarily increases theory of mind, facilitating readers’ ability to understand others’ subjective states” (2013, p. 377). The marginalization of literature within medical education, therefore, is not simply an oversight but a deeper structural failure that privileges technical mastery over moral imagination.

Medical education, shaped by biomedical rationality and outcome-based assessment, often discourages emotional engagement in favour of detachment and efficiency. While such detachment is justified as necessary for clinical objectivity, its cumulative effect may be the erosion of humane responsiveness. The displacement of narrative, fiction, and reflective engagement from medical curricula has contributed to a conception of empathy that is abstract, procedural, and measurable rather than lived and relational. In this context, empathy is often reduced to a transferable skill—one that can be assessed through standardized instruments and simulated encounters. Yet this instrumental framing strips empathy of its ethical depth, transforming it from an embodied moral response into a performance of appropriate behaviours.

It is precisely this reduction that prompted the emergence of narrative medicine as a corrective paradigm. Writers and clinicians such as Rita Charon and Abraham Verghese argue that medicine must reclaim attentiveness to stories—those of patients, clinicians, and literary traditions—to restore meaning and ethical depth to practice. Charon defines narrative medicine as “medicine practiced with narrative competence,” which she describes as “the ability to acknowledge, absorb, interpret, and act on the stories and plights of others” (Charon, 2006, p. 4). Narrative, in this formulation, is not merely a medium of information but a relational encounter that binds teller and listener. Through narrative attention, clinicians cultivate a form of ethical presence that cannot be reduced to checklists or competencies.

Literary narratives, in particular, offer a powerful means of cultivating this attentiveness. In Gabriel Weston’s *Dirty Work*, empathy does not arise from technical knowledge or procedural excellence but through moments of imaginative recognition. Weston illustrates how touch, memory, and story intersect in clinical encounters, enabling the physician to perceive the patient as more than a case or diagnosis. The patient’s life is imagined beyond the hospital bed, and this imaginative act becomes the ground of ethical response. As Weston observes, “Medicine begins with attention—attention to the body, the story, and the shared vulnerability of flesh” (Weston, 2014, p. 92). Such moments reveal that empathy is not internally generated in isolation but emerges relationally, through encounter and recognition.

However, the very concept of empathy has come under scrutiny. Jane Macnaughton has raised an important critique, questioning whether “true empathy,” understood as complete emotional identification with another, is either possible or desirable in clinical contexts. She notes that medical relationships are often brief, asymmetrical, and structured by institutional constraints, making full emotional identification unrealistic (Macnaughton, 2009). Moreover, an expectation of complete empathic access may impose undue emotional burdens on clinicians, leading to burnout or moral distress. This critique, while compelling, rests on a narrow definition of empathy as psychological transparency into another’s inner world.



If empathy is reframed not as total identification but as ethical responsiveness, this objection loses much of its force. An alternative conceptual framework can be found in the ancient notion of pity, or *eleos*, as articulated in classical Greek literature. Unlike modern empathy, pity does not claim to understand or master another's suffering. Instead, it acknowledges suffering as real and calls forth a response grounded in shared vulnerability. In Homer's *Iliad*, the encounter between Achilles and Priam offers a profound depiction of this ethic. When Priam kneels before Achilles to beg for the body of his slain son Hector, pity collapses the boundaries of enmity and hierarchy. Achilles does not claim to comprehend Priam's grief; rather, he is moved by it. As Homer writes, "And in both of them the memory stirred of their own dead" (*Iliad*, Book XXIV). The moment is one of recognition without appropriation—a recognition grounded in mortality rather than identification.

This Homeric conception of pity is neither sentimental nor condescending. It is an embodied response enacted through gestures, speech, and action. Achilles weeps with Priam, shares food with him, and returns Hector's body. Pity, in this sense, is performative rather than introspective. It manifests in what one does rather than what one claims to feel. Such an ethic aligns closely with the realities of medical practice, where care is expressed through listening, touch, tone, and presence. Unlike empathy conceived as an internal psychological state, pity is visible, relational, and ethically grounded.

Contemporary medical education, however, tends to conceptualize communication as a set of competencies to be mastered, assessed, and certified. Simulated encounters such as Objective Structured Clinical Examinations (OSCEs) are designed to evaluate whether students demonstrate appropriate empathic behaviours. While these methods have pedagogical value, they risk reducing relational care to performative checklists. Communication becomes something one possesses rather than something one practices in response to particular contexts and individuals.

Drawing on classical Greek concepts such as *aretē* (excellence or virtue) and *kairos* (timeliness), communication can instead be understood as *virtuosity*—a cultivated responsiveness that integrates skill, judgment, and ethical sensitivity. *Virtuosity* is not static or measurable in advance; it is revealed in action, shaped by context and relational demands. Within this framework, empathy—reimagined as pity—becomes a form of ethical action rather than an internal state. It is not something one has but something one does, moment by moment, through attentive engagement.

This reorientation resonates with Johanna Shapiro's call for an "ethics of imperfection" in medical education. Shapiro argues that medicine must abandon unrealistic ideals of emotional mastery and instead embrace vulnerability, uncertainty, and reflective humility (Shapiro, 2011). When educators model openness about their own limits, they create spaces where students can engage authentically with patients' suffering. Such spaces counteract the culture of detachment that often pervades clinical training. Rather than viewing emotional uncertainty as failure, students learn to see it as an integral part of ethical practice.



This perspective also aligns with Michel Foucault's notion of the "care of the self," which he describes as a process of ethical self-formation rather than self-optimization. For Foucault, care of the self involves practices that shape one's way of being in the world, cultivating attentiveness, restraint, and responsibility (Foucault, 1988). Applied to medical education, this suggests that training should not merely transmit knowledge and skills but also attend to the aesthetic and ethical formation of the medical self. Medicine thus becomes an aesthetic project—one in which character is shaped through narrative engagement, reflective practice, and embodied encounter.

Seen in this light, the prevailing conceptualization of empathy in medical education appears insufficient. Its reduction to cognitive processes and observable behaviours leaves little room for ambiguity, vulnerability, or ethical depth. Moreover, its susceptibility to instrumentalization undermines its moral force. By returning to older and richer concepts such as pity and by reintegrating narrative, literature, and classical philosophy into medical training, education can recover a more humane vision of care. Such a shift does not reject scientific rigor or clinical competence. Rather, it rehumanizes them. It affirms that clinical excellence involves not only knowing and doing but also feeling, responding, and attending. As Verghese reminds us, "The greatest sign of doctorship is to see the person behind the patient" (Verghese, 2018). Literature, narrative, and aesthetic engagement cultivate precisely this vision.

Ultimately, the contemporary unease surrounding empathy points not to its irrelevance but to the need for its reimagining. By moving beyond narrow psychological definitions and embracing an ethic of pity, narrative responsiveness, and virtuosity, medical education can resist insensibility and cultivate ethical presence. In doing so, medicine may recover its deepest vocation—not merely to cure, but to care.

Technology in 2025 intensifies both the risk and necessity of this reimagining. As medicine becomes more technologically sophisticated, it must not abandon its moral vocation. Empathy, reconceived through pity, narrative engagement, and virtuosity, offers a way forward. Medicine's future depends not merely on knowing and doing, but on attending, responding, and caring.

Emerging medical technologies in 2025 intensify the urgency of rethinking empathy. Artificial intelligence, algorithmic diagnostics, telemedicine, robotic surgery, and virtual clinical simulations promise efficiency, precision, and scalability. Yet these innovations also risk deepening the very forms of detachment this article critiques.

AI-assisted diagnostics increasingly mediate doctor-patient interactions, shifting attention from the patient's narrative to data outputs. Telemedicine alters the sensory dimensions of care, reducing opportunities for touch, embodied presence, and shared vulnerability. Virtual simulations and standardized patients, while pedagogically valuable, risk reinforcing performative empathy rather than ethical responsiveness.

However, technology need not be inherently dehumanizing. When integrated thoughtfully, technological tools can support empathetic practice. Virtual reality simulations, for example, can cultivate moral imagination by immersing medical trainees in patient perspectives, including experiences of disability, chronic pain, or



cognitive impairment. Narrative-based AI platforms can support reflective practice by encouraging clinicians to document and analyze patient stories rather than merely symptoms.

Importantly, technology exposes the limits of cognitive empathy. As machines increasingly outperform humans in pattern recognition and diagnosis, the distinctively human dimensions of care—presence, attention, vulnerability, ethical judgment—become more, not less, vital. This technological moment reveals that empathy cannot be reduced to information processing. Instead, it must be understood as relational action.

From a research perspective, this article finds that future medical education must resist technological reductionism by foregrounding aesthetic and ethical formation. Technologies should be evaluated not only for efficiency but for how they shape clinicians' moral orientation. The concept of pity, grounded in shared vulnerability rather than mastery, offers a framework that technology cannot replicate but must ethically support.

Contemporary medical education's approach to empathy is insufficient. Its reduction to measurable behaviours and cognitive processes strips empathy of ethical depth and relational meaning. Literary, philosophical, and historical perspectives reveal an alternative grounded in *eleos*—pity understood as embodied, enacted, and ethically responsive care.

As Vergheese (2018) reminds us, "The greatest sign of doctorship is to see the person behind the patient." In an age of accelerating technology, this vision is no longer optional—it is essential.

References

1. Bleakley, A. (2015). *Medical humanities and medical education*. Routledge.
2. Charon, R. (2006). *Narrative medicine: Honoring the stories of illness*. Oxford University Press.
3. Foucault, M. (2005). *The hermeneutics of the subject*. Picador.
4. Homer. (1998). *The Iliad (Book XXIV)*. Trans. E. V. Rieu. Penguin.
5. Konrath, S. H., O'Brien, E. H., & Hsing, C. (2011). Changes in dispositional empathy. *Personality and Social Psychology Review*, 15(2), 180–198.
6. Kidd, D. C., & Castano, E. (2013). Reading literary fiction improves theory of mind. *Science*, 342(6156), 377–380.
7. Macnaughton, J. (2009). The dangerous practice of empathy. *Medical Humanities*, 35(1), 1–6.
8. Owen, W. (1994). *The war poems*. Wordsworth Editions.
9. Shapiro, J. (2011). Walking a mile in their patients' shoes. *Academic Medicine*, 86(2), 188–193.
10. Twenge, J. M. (2014). *Generation me*. Atria Books.
11. Vergheese, A. (2018). A touch of sense. *Health Affairs*, 37(1), 11–14.
12. Weston, G. (2013). *Dirty work*. Jonathan Cape.