Reviewer's report

Title: Clinical realism: A new literary genre and a potential tool for encouraging empathy in medical students.

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Major compulsory revisions are numbered in bold other comments are discretionary revisions.

The paper analyses, with a grounded theory constructivist approach, the creative writing of six undergraduate medical students during the final session of a creative writing course and additional material about the development of their characters and comments from the end of module essays (lines 120-127). The authors conclude that a medical realism approach to writing, combined with creating and then repeatedly writing about the same fictional character ... can potentially help increase the empathic ability of students (lines 357-361)

1. The authors should explain how creating a fictional character could do anything other than lead the creator to step into their character’s shoes (line 342) especially among students who have self-selected for a creative writing course. Can the authors explain why this is an important finding? Was it also surprising?

2. The problem of acceptability that they acknowledge (lines 352-6) remains. If empathy is important for all medical students and doctors, how do they suggest this might be overcome or do they concede that this has a limited potential?

Measuring empathy. Empathy has been described as difficult to define and hard to measure. Definitions vary and the systematic review referenced notes the importance of a clear definition for the purposes of research [1].

3. I think it would help to clearly define the features of empathy that are being described in this study and how they link to which definitions of empathy, and why one (or more) rather than others should be selected.

One definition is suggested (lines 324-6) but it’s not clear if any is used. I think that the findings do show features of empathy, but empathy scales are
recommended in the systematic review the authors reference, and without also using them, it is impossible to show that students cognitive or affective empathy was affected, or that it significantly increased over the time of the course [1].

Developing fictional character may be evidence of appreciating the phenomenology of illness, but without real patients, I’m not sure if it is evidence of either, or why it should be preferred to engaging with patients’ own stories. The importance of engaging with real patients’ lived experience of illness, their narratives and their interpretations is already established [2–5] and Kleinmann in particular argues that

Doctors must go beyond autobiographical introspection and reporting of collegial dialogues to write richly and in depth about what their patients and families are actually experiencing in their own realities.

Narrative humility, the appreciation that there are many stories to be told about a patient, is an important perspective to add here, how, for example might a medical students fictional account differ from that of a real patient, a carer, a doctor etc? [6].

4. A brief discussion comparing the pros and cons of using fictional vs. real accounts would be helpful to explore these issues.

Relating the themes, e.g. stigma to qualitative research [7] would be one way to demonstrate that the students imaginary efforts were shared by real patients. There are a lot of illness narratives and I’m not entirely sure the conclusion that people with chronic physical disorders and illnesses remain almost unacknowledged, is justified (see Jurecic for examples [8] and http://www.healthtalk.org/)

5. The study involved only six students and there are details missing that should be included, for example; ethnicity, gender, age, previous experience and why/how they self-selected for the course.

There is no discussion about why the students’ approaches differed (line 137), for example did postgraduate entry female students with a humanities background show greater empathy and a more reflective approach? In line 291 it says, some reported increased empathy towards their character as the course progressed.

6. It would be important to know how many did (and also did not) report increased empathy and why this might be.

As a reader, I suspect that the students are naturally highly empathic with an established interest in literature and the humanities, but I’m left wondering if only some of them reported increased empathy, there might be much less potential for other students who are less empathic and/or not interested in such a course. If empathy is as important as some believe, then an intervention needs to be suitable for all students. The illness (and empathy) related themes (lines 216ff) are described but I’d be interested in how many students described each of them
and in what contexts. I was intrigued (line 277) that some were not pleased to be allocated patients with socially stigmatising disorders. This seemed to me to be one of the most important findings, especially regarding empathy which is almost certainly harder with patients that professionals have little in common with.

7. I think this could have been explored in more depth, for example what features of both the patients and the students could have accounted for the stigma?

Beyond empathy

Empathy is not without its critics. Smajdor [9] argues that etiquette or courtesy is more important and Jurecic [10] argues that empathy is complex and potentially harmful, by, for example demanding the suspension of critical judgement which is essential in medicine, or being used to reinforce unequal relationships of power. It isn’t clear to me whether empathy is a means to an end - of patient-centred/focused care for example, or an end in itself. Others have argued that engagement with a patient’s lifeworld (which is what this paper appears to show, rather than empathy per se) is important for certain patients in particular circumstances [11].

8. It is important for the dangers of empathy to be discussed (briefly) and the distinction between engagement with a patient’s lifeworld and empathy to be clarified.

Reports about the erosion of empathy emphasise that though good (empathic) behaviours can be taught and assessed as competencies, they need support and nurturing to ensure they are resilient under the pressures of clinical practice [12–14]. 9. I’d like to know how the authors think this intervention might survive or be adapted to have lasting effects.

Despite my criticisms, I have personally found writing fictional accounts of my patients’ illness experiences immensely valuable, for example:
Shame https://abetternhs.wordpress.com/2012/11/16/shame/ and
Loneliness https://abetternhs.wordpress.com/2013/05/04/loneliness/
But I still don’t believe I am necessarily more empathic for it
https://abetternhs.wordpress.com/2013/12/20/empathy/

It has made me much more interested in the phenomenology of illness, epistemic justice, narrative humility and the use of illness narratives in medical education [2, 6, 15, 16]
https://abetternhs.wordpress.com/2014/06/12/lessons/

Summary.

I think that this intervention is potentially immensely valuable for those that partake, but it has a limited potential for the reasons the authors themselves acknowledge.

I think the paper needs more clarity about what it is measuring, more detail about the participants and a deeper, more critical discussion of the findings before it is
Level of interest - An article whose findings are important to those with closely related research interests

Quality of written English – Acceptable

Declaration of competing interests – I declare I have no competing interests

Next step - Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests