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The Practice of Being Human: Narrative Medicine and Cultural Representation

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The Practice of Being Human: Narrative Medicine and Cultural Representation

The Doctor as a Repository of Secrets

A doctor is used to seeing herself as a sort of detective. This is the impetus behind what Michel Foucault termed the *medical gaze*. It is, at heart, a quest for the truth, founded on the belief that with the right tools, the doctor has the ability to read the body and discover what ails the patient. Many of the outcomes of the medical gaze – the careful observation and cataloguing of various symptoms, the abstraction of the patient into his bodily components, the reliance of the doctor on medical technologies and the subsequent distancing effect this creates within the doctor-patient relationship – arise because of the doctor's motivation to diagnose an illness and effect a cure. In hot pursuit of the truth, the doctor uses whatever resources science has made available to her to unravel the mysteries of the patient's body. The patient becomes a sort of a puzzle or a case study for the doctor to solve.

But while the doctor may play the detective, in the course of her profession she also functions as a confessor and a confidante. Whether through compulsion or necessity, people share their most intimate secrets with their doctors. Sometimes this occurs involuntarily, for the body bears evidence of their proclivities and desires, manifesting people's weaknesses and transgressions. The doctor may not be as comfortable with playing this role, for at first it seems to be at odds with the impassive, unbiased and scientific quest for truth that the profession champions. Doctors are, after all, expected to remain unperturbed even when faced with disturbing scenes of trauma or inexplicable disease. It is no coincidence that William Osler titled his 1889 valedictory address "Aequanimitas", and took the occasion to emphasise that for a doctor, 'a calm equanimity is the desirable attitude' (Osler 24). How then, is a doctor to deal with the messy, lurid, shameful and sometimes unuttered secrets of her patients? Sharing secrets invites a certain complicity, an emotional intimacy with which doctors may feel uncomfortable with or for which they may not feel not sufficiently trained for.

In the case of Melanie Cheng, whose day job for the past decade has been as a General Practitioner (GP), the solution to this conundrum takes the formal expression of writing fiction. Cheng entered the literary scene with a collection of short stories, *Australia Day* (2017) that won the Victorian Premier's Award for an Unpublished Manuscript in 2016; after publication it won the Victorian Premier's Literary Award for Fiction in 2018. Her first novel, *Room for a Stranger* (2019) was published recently. Cheng's ascendance reflects important changes in the Australian literary landscape, which has become increasingly open to authors

from diverse backgrounds and more interested in stories that capture different facets of Australian culture. Today, there is greater scope for non-Anglo writers to be considered as part of the mainstream as opposed to the 1980s when such writers were cordoned off in the category of 'migrant writing'.¹ Cheng's work is accented by a certain optimism for Australia's multicultural future, a disposition which prompted the critic Robert Wood to observe that: 'It is not only that Cheng's book is "diverse" but that these individual characters suggest the ways in which we might move forward' (Wood). This essay is one of the first to appraise Cheng's work from a scholarly perspective, and I argue that Cheng's unique, multifaceted perspective of Australia is not simply derived from her Chinese cultural background but, more significantly, from her medical training and practice.

Even as Cheng's literary career has taken off, she has continued to work as a GP and shows no sign of wanting to exchange one job for the other. When asked by an interviewer about how she balances her two careers, she said: 'I like the mix. It's a great privilege to be somebody's family doctor – patients share intimate details of their lives with me. Through the process of writing I try to make sense of the grief and trauma and joy I observe in my life and my work' (Cheng "Unlikely"). Her example shows how well the twin roles of doctor and writer complement each other and suggests that having an outlet for creative expression can assist a doctor with handling the responsibility of keeping other people's secrets. However, as I go on to show in this essay, writing such as Cheng's, inflected by a medical perspective, can have an importance beyond the clinical setting. It casts light on the unique perspective of society to which medical practitioners are privy and prompts us to re-examine the role that literature might play in fostering empathy. This extends beyond the considerations of the doctor-patient relationship, into the diverse spectrum of people that may be found across any community.

Modern medicine distanced itself from the quacks and charlatans of the past by emphasising its basis in scientific method. Without doubt, this empirical approach succeeded. In *The Making of Modern Medicine* (2011), Michael Bliss captures some of the excitement and hope that accompanied medical breakthroughs in the nineteenth and twentieth centuries, before noting that after World War II, the effectiveness of modern medicine was no longer questioned. He writes: 'Medicine's benefits to patients were so obvious and so important that

¹ A useful overview of the shifting categories of 'migrant' and 'multicultural' writing is provided by Gunew and Ommundsen (2018). They observe that over the past thirty years, 'there is no doubt that both [Australian literature and literary criticism] have become more outward looking and culturally diverse' (35), even as they caution that non-Anglo writers continue to struggle unduly against '[s]tereotypes of ethnic identity and cultural authenticity' (35).

the central problem became how to afford to pay for all that was emerging from the cornucopia' (89). However, the emphasis on doctors as scientists pushed aside other aspects of medical practice, an oversight that the field of narrative medicine seeks to redress.

One of this field's key issues is the way that the impartial, methodical and evidence-based approaches of the scientist often seem to be at odds with the highly intimate relationship of caregiving in which a doctor engages. These contradictory aspects of medical practice are implicit in the term 'detached concern' coined by the sociologist Renée Fox to capture the two positions that a doctor is encouraged to take towards a patient. Fox suggested that a doctor needed to 'maintain a dynamic balance' between 'detachment' and 'concern' in order to treat the patient effectively.²

The difficulty of maintaining two opposing attitudes is self-evident. Indeed, the very notion of 'detached concern' has been directly challenged by bioethics philosopher Jodi Halpern, who refutes the idea that a doctor can successfully remain both detached *and* concerned. She suggests that the orientation of medical training towards the scientific method means that medical practitioners are more likely to express detachment in a professional setting rather than concern. This is indicated in Foucault's description of the medical gaze, when he says: 'It is a gaze of the concrete sensibility, a gaze that travels from body to body, and whose trajectory is situated in the space of sensible manifestation' (Foucault 120). In the coolness and clarity of the medical gaze, we do not sense a person of flesh and blood but rather the surgical precision of a steel instrument.

Doctors, however, remain subjective, temperamental and susceptible to the fluctuations of their environment. We must remember that whilst William Osler exhorted doctors to stay outwardly calm, he made it an imperative for the patient's sake. In the same "Aequanimitas" speech, he said: 'In a true and perfect form, imperturbability is indissolubly associated with wide experience and an intimate knowledge of the varied aspects of disease' (Osler 23). In other words, an equanimous attitude that conveys authority is reassuring for the patient. This did not mean that a doctor's inner turmoil was necessarily quelled or deadened, or that the doctor herself did indeed feel this sense of mastery. It can often be difficult for doctors to admit to experiencing any such emotional tumult or uncertainty, given how closely a calm collectedness is associated with professionalism. This reticence merely reinforces the hierarchy between doctor and patient encouraged by the medical gaze. Under this gaze, the doctor is an authority figure who cures the patient. The doctor is able-bodied and truth-seeing, while the patient is diseased and ignorant of his body's failings. Within

² Fox originally discussed this dynamic balance between detachment and concern in *Experiment Perilous* (1959), see especially p.86. She went on to develop this further in Fox and Lief (1963).

this dyad, the roles of doctor and patient are clearly demarcated and never reversed.

The need to live up to these expectations can be a problem because, as Halpern explains, the failure of a doctor to acknowledge her own emotional state can significantly impair her ability to do her job. Halpern writes that: 'Physicians need to recognise characteristic patterns of emotional thinking because errors result from such influences even when physicians are not emotional in the ordinary sense' (Halpern 26). She suggests that detachment risks introducing two main categories of error in diagnosis: those caused by avoidance and those of bias. Due to their own personal history of trauma, or simply through ignorance, doctors may abstain from asking patients about subjects they themselves do not feel comfortable about. Avoidance can impede accurate diagnosis by shutting down certain avenues of useful inquiry. Errors can be further introduced by a doctor's own personal bias. Such prejudices are a perfectly normal part of being human, but if the doctor is unaware of any such ingrained biases then she is unable to correct for them.

Melanie Cheng's writing, by contrast, frequently dwells on the emotional lives of characters. She has said that her writing practice developed in tandem with her GP practice: 'Once I finished my GP exams, I suddenly had to fill the void left by my studies and I filled it with writing' (Cheng "Untitled"). Reading *Australia Day*, it is apparent that her work also functions as a means of processing the encounters she has with people in her everyday job. Writing fiction allows her to complete the narratives that may be at loose ends in real life, or to explore any conflictual feelings that are brought up by medical practice. At the same time, this willingness to dive into other peoples' lives translates into a powerful and original literary voice, one that depicts social complexity instead of the rehashing of stereotypes or pathologies.

For example, in "Things We Grow", Cheng depicts the complex tangle of emotions experienced by a grieving woman who has just discovered she is pregnant. When the pregnancy test comes up positive, there is no immediate elation or fear, no big rush of emotion. There is instead quiet meditation and a gentle indication of all the things this immense news stirs up: grief for her lost partner, sorrow for a previous pregnancy that they aborted, trepidation about the future and wonder at her body's little secret. A reductive reading would be to say that this woman demonstrates classic symptoms of depression, but Cheng's story helps us understand how logical her emotional responses are, given her overall situation.

A flattening out of the doctor-patient hierarchy is healthy for the doctor herself, for it allows her to admit that she has limited powers and is, after all, another fallible human being. This also gives us scope to re-evaluate the role of

the doctor. Rather than seeing the doctor solely as a detective, a more reasonable approach would be to also see the doctor as a witness. Far from being a sign of weakness, Rita Charon emphasises the role of listening in terms of a doctor's practice. In *Narrative Medicine: Honouring the stories of illness*, she writes: 'Reorienting our clinical practice toward the *possibility* of bearing witness to our patients' suffering requires training and skill in listening to patients' self-narratives and in caring for the self-who-listens' (181). If a certain humbleness befits the doctor in her interactions with the patient, then we might appreciate that even when the doctor is not capable of finding a cure, there is still value in the act of witnessing acts of suffering and survival.

Melanie Cheng takes this role of witnessing and, through fiction, makes other people's stories into her own. She has been keen to let it be known that she would never violate a patient's confidentiality and that her writing is no crude appropriation of her patient's stories.³ Instead, her act of committing these situations to record is a way of acknowledging that she herself has been changed by these encounters. It is a form of 'honouring' her patients, as Charon terms it, and the act of paying tribute to those patients already begins to reconfigure the historic dynamic between patient and doctor. Cheng's work as a writer stands as a testament to the people she has treated. Her fiction is a means to synthesise events she has witnessed and to gain a deeper understanding of people's behaviour. It is an exercise in empathy but also a means of dealing with the difficulties of a doctor's job, a forum in which she can reclaim a sense of authority and authorship over events that where doctor and patient may be equally helpless. Fiction writing is a place where Cheng can dispense with detachment once and for all, embrace an instinctual concern for her patients, and safely relieve herself of the burden of other people's secrets.

Rethinking Practice

We say that practice makes perfect but this maxim indicates the extent to which a linear idea of progress has become central to modern culture and in particular to the scientific project. The notion of constant betterment is so pervasive that doctors must deal with implicit expectations that, if they are good enough, they should be able to find a cure and return the patient to health. However, the concept of a cure is actually at odds with the idea of having a *practice*. If the doctor is supposed to cure the patient, then she is fighting a losing battle, for not every ill can be cured and not every patient can be helped. If

³ In an interview Cheng states: 'I would never write about the specific details of patient case stories, but being a GP allows insights into situations I wouldn't have otherwise been afforded. It constantly challenges my assumptions, too, encountering different people and allowing me to be armed against stereotypes' (On).

we dispense with the conceit that healing equates to a statistical agglomeration of 'cures', then a space opens up to view the doctor's work for what it really is – an ongoing practice where the doctor helps to stave off what eventually becomes an inevitable decline. The psychiatrist Jack Dominian, who was also a Catholic theologian, affirms the medical encounter as one that establishes a relationship between two people: 'I want to emphasise first and foremost that to function as a doctor one has to enter into a relationship with another human being, the patient' (Dominian 1925). Recognising the doctor-patient relationship as one that affects the doctor equally as much as it does the patient is the first step in understanding the elements that may drive doctors to view their patients in antagonistic rather than supportive ways. We can then start to see that the issues doctors face in the workplace may find their corollaries in other professions.

Cheng's stories do not always deal overtly with medical situations, but rather with the emotional toll incurred by professional and personal conflicts. The doctor is not alone in the need to temper compassionate responses so that she can do her job effectively. In "Ticket-holder Number 5", Cheng uses the example of Tania, who works at the counter of a driver's registration office, to show us how succumbing to an emotional response makes an individual vulnerable to manipulation. Tania has an encounter with a young widow who needs to sell her deceased husband's car but doesn't have the original copy of her husband's death certificate. The woman says she has a three-year-old daughter at home and is also thirteen weeks pregnant. We are told that 'People had cried in front of Tania before, many times – on average once per week – but she had never given in to them, no matter how sad the story' (Cheng *Australia* 64-65). But the widow's predicament seems so close to Tania's own experience of having to raise a daughter as a single mother without any assistance, that this time she is unable to stay objective. Cheng describes the emotions that overwhelm Tania: 'The overall effect was one of disorientation: of being bombarded with so many emotions at once that it was impossible to focus on just one. All she wanted to do was get away, get to some place where she could breathe again. And in her desperation to escape, she broke a cardinal rule of customer service. She said: 'I'll see what I can do' (65). Tania decides to make an exception, and puts the forms through for this woman, pretending to have sighted the original documentation. But the pleasure she feels from performing a good deed is short-lived – the story ends with a throwaway comment by one of Tania's colleagues, who observes that the customer had been in the week before claiming that her brother had died in a car crash and she needed the registration changed to her name. The colleague says: 'She should've gone into acting. Better than Cate Blanchett or Nicole Kidman. Almost had me fooled' (68). Thus, Tania's spontaneous act of compassion goes unrewarded. She is revealed instead to have broken the rules

for no reason. Rather than being a hero, she is a sucker, a dupe, a woman who has failed to do her job properly.

The doctor-patient relationship is considered more directly in "Macca", a piece which revolves around Dr Garrett, a GP, and her court-ordered patient, the titular Macca. With deft and swift strokes, Cheng provides an overview of Macca's progression from an alcoholic who reluctantly sees Dr Garrett as a means of staying out of prison, to someone who wants to try get clean, and finally to someone who has fallen off the wagon. The story is told from Dr Garrett's point of view, and we see the difficulty she has in maintaining a distance between her and her patient. Late one afternoon, as she is doing paperwork, a colleague gently reminds her not to take on the burdens of her patients. He describes a revelation he had during a consult that 'None of this was my problem' (41). His advice to her is: 'Help the poor buggers as much as you can within the confines of this room, but whatever you do, don't take their shit home with you' (41). Despite this warning, Dr Garrett finds herself unable to stop thinking about Macca, wondering if he is taking his medication and how he's doing more generally. For a short period of time, Macca seems to be improving and this period of recovery only serves to further involve Dr Garrett in his case. It makes the blow all the harder when he disappears and leaves town in breach of his court order. Unable to simply accept that Macca is no longer her problem, Dr Garrett calls his mobile number, hoping to somehow bring him back to recovery. When he picks up, Macca is nonchalant. He ends their brief conversation with the words, "She'll be right" (47). After this final interaction, what lingers more than Dr Garrett's own concern is her desire for Macca *not* to think she cares. She suspects that even the simple act of calling him may have ventured into unprofessional territory by appearing to be a form of preferential treatment. Instead of emphasising Dr Garrett's sense of responsibility, the story ends with her wishing she could explain to him that 'in spite of the impression she may have given him – deep down, she doesn't care' (47). The reader warms to Dr Garrett much more because she is a doctor who genuinely cares for her patient, but she sees it as a personal failing that she cannot disengage from him as quickly as the bureaucratic system requires her to.

This is where it can be beneficial to consider the practice of writing. Unlike medicine, writers do not have a baseline by which to measure success or 'cures'. Writers may work towards getting a text published but they know that it is never really finalised. The text can always be redrafted or rewritten. The art of writing is very much focused on the *process* rather than the endpoint. For example, the American short story writer Andre Dubus here describes making a breakthrough in his writing practice: '[...] I realised I had been writing horizontally. I'd been writing to a scene to get to the next scene. When I wrote [the story] "Anna," I

didn't think about the next scene. I thought about the sentence, the moment. [...] And it was done in one draft. So by writing more slowly, I wrote more quickly' (Bonetti 35). As Dubus suggests, staying too fixated on the endpoint can actually impede the writer's ability to follow their creative impulses and pursue genuine leads. Likewise, if doctors were able to focus more on being present and attentive with each patient in the time they have together, rather than anticipating the treatment they should recommend or thinking about the other patients they must see, then this would likely lead to better patient outcomes.

Empathy is often proposed as an important way to counter the de-humanising qualities of the medical gaze, and it has been suggested that writing techniques can assist in helping doctors see things from their patients' point of view.⁴ Whether the ability to imagine yourself in someone else's position translates into a personal feeling of empathy, is a question that is up for debate. Rebecca Garden warns of how easily 'reflective writing' can end up merely extending rather than mitigating the medical gaze. If the power differential between the doctor and the patient is not properly acknowledged, then a reflective exercise may simply encourage the doctor to project her own narrative onto the lives of patients. As Garden notes: 'Empathy depends on the experiences and imagination of the person who is empathising, and this dependency has the potential to obfuscate or exclude the patient's suffering and the meaning the patient makes of suffering' (Garden 555). For this reason, it is understandable that others have chosen to pursue the avenues opened up by narrative methods in medical training without dwelling too much on one single affective response.⁵

Whilst being aware that it may not be necessary to actually *feel* empathy for a patient in order to treat them in an empathetic manner, we can see that there are few downsides to fostering a compassionate rapport between doctors and patients. However, a significant challenge to a doctor's ability to empathise with her patient is the sheer volume and range of people that a doctor is brought into contact with. The field of narrative medicine has shown that by learning

⁴ Describing a Parallel Chart exercise, where she gets medical students to write about their emotional responses to patients, Rita Charon writes: 'By administering psychological scales that measure empathy and perspective-taking to students, we are generating evidence that students who write are more likely than those who do not write to improve their ability to adopt the perspectives of others. Our provisional understanding of this process is that clinically relevant narrative writing and disciplined examination of that writing in groups improves students' skills in seeing from their patients' point of view, a capacity requiring cognitive and imaginative flexibility. The ability to shift one's perspective in order to see events from others' points of view may be one critical and currently missing skill in health care professionals – and one that can be taught' (Charon 174).

⁵ Maura Spiegel and Danielle Spencer suggest that empathy is not in itself a useful term for clinical practice '[...] because there are so many dimensions to any human interaction that to focus on one idealised relational affect or dynamic is simply inadequate' (Spiegel and Spencer 41).

techniques of narrative analysis, doctors can turn to media forms as a resource for practising the art of imagining the world from different points of view. We must understand, however, that this approach is, in itself, limited to the variety of viewpoints made available by the media.

Arguments for diversity have tended to focus on the audience: the positive effect that seeing recognisable versions of themselves in the media can have on someone's well-being. For example, the sociologist Myria Georgiou distinguishes between the producers of media content and the content itself, arguing that it is important to have diversity in both areas. She writes that: 'Both kinds of representation – in production and in content – have consequences for the ways audiences construct perceptions about migration, race and ethnicity' (Georgiou 167). The belief that seeing recognisable, relatable images of one's culture in the media can make a significance difference spurred the Pulitzer-Prize winning Dominican author, Junot Diaz, to release a children's book in 2017. Diaz describes the importance of representation in much more polemical terms, seeing the absence of accurate representation as 'abusive'. When an interviewer questioned his use of this term, Diaz was adamant in his response: 'I think that if I deny you all images of yourself and I starve you of any healthy representation, that's abuse. We could say that, "Yes, well, it's the market that did that, it's all these other forces," but ultimately the reason that we don't have equity, the reason that we don't appear in stories, is because of histories of exclusion and oppression' (Balkissoon). Diaz draws attention to the underlying historical and colonial factors that not only determine who finds representation in the media but also the ways in which certain stereotypes come to be reinforced and normalised.

Melanie Cheng suggests there is another reason why it is important to cultivate diversity in the media: as an empathetic exercise for readers. In a short blog post called "Just Like Me", Cheng writes: 'The need for children and young people to see themselves reflected in what they read is one very strong argument for diversity in literature. But there is another, perhaps even more important justification, and that is the need for readers to empathise with characters who are different to them. [...] Furthermore, if our art doesn't reflect the community in which we live, then it risks being inauthentic' (Cheng "Just"). For Cheng, the act of reading is a means of practising empathy, often the closest we will be able to get to sharing in someone else's life experience. This ability to sample other people's realities is not only an important means of fostering connections between individuals and communities, but is arguably a central part of helping the individual understand their own broader social context.

One of the most striking aspects of Cheng's writing is how she eschews the biographical subject matter typically expected of a Chinese-Australian woman and instead writes assuredly from the vantage point of a disparate range of

people. Only two of the fourteen stories in *Australia Day* focus on Chinese characters. For the other twelve stories, Cheng turns with a tender probity to White Australians, Asian Australians, and Australians of Middle Eastern descent. She directly attributes the confidence with which she writes from such a wide range of cultural perspectives to her medical practice: 'Being a doctor is a privilege and while it goes without saying that I would never write about specific patients, the insights I gather from talking to people from all walks of life allow me to write confidently about fictional characters and situations outside my lived experience' (Mitchell). While she is aware that writing outside of her cultural background leaves her open for criticism, she asserts how her medical practice has given her insights into the world beyond her lived experience.⁶

In this manner, Cheng highlights the way in which a medical practice is linked to a writing practice, and how one can enlarge the other. Literary techniques can help medical practitioners better understand and communicate with their patients, but the practice of medicine also has the capacity to expand the types of stories that are told in literature. In another interview, Cheng has said: 'I think, general practice in particular is all about stories. People come in and tell you their stories. And sometimes their stories, they've never told anyone else' ("Interview"). Her willingness to frame her medical practice in narrative terms suggests an alternate approach to the doctor-patient relationship. Seeing people in terms of their stories qualifies as a distancing technique which may help control her emotional responses, but one that offers an important counter to the biomedical focus of the medical gaze. Stories are inherently individual and emotional. The act of storytelling requires both a speaker and a listener – it is a shared activity between two participants. Stories, unlike bodies, can be passed on and absorbed. Cheng is altered by the stories she hears and by the events she witnesses. Her act of writing these stories transforms them into something else, but also imbues the entire procedure with a sense of meaning. Rather than feeling pressure to be a knowledgeable, authoritarian figure of the doctor, the practice of medicine, as with the practice of writing, becomes an ongoing process of constant discovery and revelation.

The Medical Gaze's Human Eyes

It is dangerous to talk about universals, but illness and mortality are two inarguable facts of the human condition. Every individual may die a different

⁶ Elsewhere, Cheng has written about how she understands her surname gives her a certain credence if she writes about Chinese characters: 'Rightly or wrongly, I know that, on this occasion at least, my name will give my story credence. But the corollary of this is that my credibility may be questioned if I decide to write from the perspective of an Arab woman, or an African American man, or a Burmese refugee' (Cheng "By any other name").

death, but it is a steadfast certainty that every one will die. It is revealing that in his seminal essay, "Literature and Medicine: The State of the Field", the cultural historian George Rousseau sees fit to remind us of what should be obvious – that the doctor is also a human being. Pointing out the doctor's ordinary fallibilities, Rousseau writes: 'He too will grow old and die; he too suffers fears and anxieties as do his patients, and these colour his approach to the whole world, including his profession. Like the writer, he possesses an imagination and there is no reason to believe he suspends it – or can suspend it – in actual medical practice' (Rousseau 414). The doctor is confronted with discomfiting examples of illness and death on a daily basis, and must suppress his or her own fears of death in order to treat patients. Little wonder that the dehumanization of patients becomes a common issue that health care workers must guard against.⁷

Cheng posits an alternative approach – namely, the use of storytelling as a bridge to connect doctors to patients. Her ability to synthesise other people's stories and make them her own is a variation on what Stevan Weine has called the 'witnessing imagination'. Describing his own work of witnessing, Weine notes that listening to testimony is only the first step in a much longer process. When it comes to sharing testimony, both the testifier and the witness enter a space where the narrative can be rewritten. From a psychological perspective, this benefits the testifier, for it allows him to revisit the traumatic event and begin to reshape its significance in his life. But equally important as the recording of testimony is the communication of this testimony to others. Weine writes: 'To communalise trauma is to bring survivors' personal stories into the collective dialogue in such a way that the larger group sees the trauma and its consequence as partly theirs, implicating each and every member. In contemporary society we all too often fail to see that what is personal and psychological is called communal, cultural, and political' (Weine 177). We can see Cheng's work as emerging from this process of sharing and rewriting stories, drawing attention to moments of pain that she has observed, whilst managing to preserve her patients' privacy.

An unexpected outcome of Cheng's personal process is that her work ranges beyond the subject matter usually covered by debut authors. In the field of Australian literature, writing by ethnic minorities used to be classified as 'migrant writing' or 'multicultural writing' and there was a tendency to classify non-Anglo authors according to their specific cultural and ethnic heritage.⁸ Thus, we refer to

⁷ Haque and Waytz identify six major reasons for why dehumanization is endemic in medical practice, as well as suggesting that each of these elements can be tempered by simple amendments to the doctor's methodology during the course of treatment (Haque and Waytz).

⁸ There is not space here to go into the demands of the marketplace or the conditions of the publishing industry that facilitate and perpetuate this sort of minority marketing, but Ken Gelder and Paul Salzman

the Greek authors Christos Tsiolkas and Antigone Kefala, the Chinese Brian Castro, the Lebanese David Malouf or the Vietnamese Nam Le. Melanie Cheng's work, by contrast, defies easy classification. Her collection of stories places Chinese characters alongside those from other ethnic backgrounds. Each story presents us with the unique voice of an individual, but the volume stresses the many different cultural facets of Australian life. If, in the past, it has been the prerogative of white Australians to determine where the parameters of Australian identity lie, then in Cheng's book we see a new move to take charge and redress the stereotypes commonly associated with ethnic minorities. Her familiarity with different communities – a knowledge gained from her medical practice – translates into an easy cultural fluency in her literary work.

Returning to the role played by empathy, we may not personally know individuals who match every one of the characters represented in *Australia Day*, but having this ability to dip into their lives gives us a truer sense of the diverse, multicultural society in which we actually live. Here is where the democratizing impulse of the medical gaze assists us – the reduction of people to discrete bodies, similar but individual. Cheng goes one step further, however, by augmenting her medical gaze with a careful storytelling that reimbues those bodies with emotion, humanity and dignity. Her role as a doctor emboldens her to enter those spaces of communion with individuals, regardless of their background. In a variation of the medical profession's Hippocratic Oath, where a doctor promises to help the sick, regardless of who they are, Cheng's stories give an equal weighting to the voices of individuals, regardless of their ethnic background.

To be able to administer a treatment, it may be a necessary step for the doctor to focus on the patient's body from the individual inside. The distancing effect of this separation enables the doctor to overcome any personal emotions of disgust, fear and reticence that are a natural response to illness and trauma. But the second step must be a re-integration with the individual who has been placed aside. Storytelling can function as a bridge between doctor and patient, not only in terms of helping the doctor find empathy for the patient or as a diagnostic tool, but also in terms of acknowledging that doctor and patient are creating a new story together. This is the story of treatment, which has equal capacity to affect both parties. Thus, writing and medicine are actually two sides of the same practice – the practice of being human. Whether reading a literary text or learning details about a patient's life, the doctor is exploring other paths that, but for a twist of fate, she might have taken instead.

document the changing times in *The New Diversity: Australian Fiction 1970-1988* (1989). For a summary of the political history behind Australia's multicultural writing see Ommundsen 2007, and for a concise overview of the academic scholarship that currently exists on multicultural writing see Gunew 2017.

As we have seen with the example of Cheng's work, this also has important ramifications for the production of literature. I have been discussing the importance of diversity as a means of engaging readers in the use of empathy, but we can turn back to the other important aspect of diversity and argue that Cheng's portrayal of a multicultural society has significance for the audience, as well, in terms of representation. Her expansive cast of characters allows a wider range of people to see reflections of themselves in the established media. While Cheng may help individual patients, the greater impact from her medical practice comes from the vision of society she puts forward in her writing. This is not a vision of an assimilated Australia, but an example of how various communities can co-exist. There are fractures and conflicts, misunderstandings and frustrated attempts to understand each other. There are moments of empathy and connection to be found through our common experience of the human condition: the frailty of life, the certainty of death, the grief we all feel in the face of mortality.

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