What Matters Most? The Power of Kafka's *Metamorphosis* to Advance Understandings of HIV Stigma and Inform Empathy in Medical Health Education

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Abstract

HIV stigma, a social-medical problem, continues to confound researchers and health professionals, while undermining outcomes. Empathy may reduce stigma; its absence may predict stigma. This research investigates: How does Kafka's *Metamorphosis* advance understandings of HIV stigma in medical health education? *Metamorphosis* amplifies the sociological-relational mechanisms fostering HIV stigma. It offers a multi-disciplinary, responsive space for ethical, humanistic and clinical inquiry to meet: enabling students to consider how social structures shape health inequities, moral, social experience, and their professional identity within. *Metamorphosis* may ultimately promote medical health humanities' social mission—allowing literature to unfold such revelations towards greater equity in health.

Keywords Stigma · HIV and AIDS · Empathy · Social determinants of health · Medical health education

Introduction

Stigma presents a perplexing problem for medicine and society. While stigma is a social construct, it remains a significant contributor to morbidity and mortality, globally (Hatzenbuehler, Phelan, and Link 2013). Stigma's deleterious health effects are likely even underestimated, since numerous health conditions and disorders are stigmatized, from disabilities to mental health and substance use disorders (Pachankis et al. 2018; Remien et al. 2019). Broadly defined as a "mark of disgrace associated with a particular circumstance, quality, or person" (Oxford English Dictionary 2021), stigma functions by affixing a negative label to individuals as a result of their condition, disease, or membership within a marginalized community—effectively "spoiling" their social identity (Goffman 1963, 5). Foundational theories of stigma are rooted in the work of early sociologists and philosophers who sought to make sense of social exclusion in relation to power and culture

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(Goffman 1963; Bourdieu 1977; Foucault 1995). Conceptualizations have since evolved to embrace the role of structural inequalities and other mechanisms that foster stigmatization in social context (Crocker, Major, and Steele 1998; Link and Phelan 2001; Parker and Aggleton 2003; Pantelic, Sprague, and Stangl 2019). Yet, despite increased theoretical and practical understanding from different fields, stigma continues to confound researchers and professionals (Geter, Herron, and Sutton 2018). Indeed, stigma remains persistent and pervasive, generating adverse mental and physical health consequences for people, globally—especially for those living with the human immunodeficiency virus (HIV) (Rao et al. 2019; UNAIDS 2020a).

HIV, and its end-stage, acquired immunodeficiency syndrome (AIDS), continue to live large in the global public imagination. HIV differentiates itself from other stigmatized conditions as an infectious disease: one contracted primarily through sex. HIV has no cure, not even a vaccine. HIV and AIDS have long been associated with shame, secrecy, and death across settings (Shilts 1987; Power 2003). In US social-cultural context, HIV-related opportunistic infections were visibly prominent among gay men in the epidemic's early years. Ugly lesions, angry rashes or wasting were hallmarks of illness provoking alarm, dread and discrimination against those living with the virus, while infringing their human rights and dignity (Sontag 1989; Gruskin, Mills and Tarantola 2007).

The year 2021 marked forty years of a global HIV epidemic that has claimed more than thirty-six million lives to date (UNAIDS 2020b). Over these decades, people living with HIV have experienced well-documented stigma, but especially racial, ethnic, sexual and gender minorities, sex workers, users of substances—and women. These key populations may also experience intersectional stigma associated with being sexual, racial, ethnic or gender minorities and/or other negative social identifiers, e.g., histories of violent victimization (Turan et al. 2019; UNAIDS 2020a). Important treatment advances have extended life expectancy and references to a so-called 'end of AIDS' are made (see Walker 2020; Tsampiras 2020). Yet stigma thwarts this policy goal at global and national levels. HIV stigma undermines biomedical advances in treatment and prevention across the entire HIV care continuum by reducing people's access to HIV testing, care, onward adherence, and viral suppression (Logie et al. 2018; Rueda et al. 2016). Among one hundred persons living with HIV in the US today—a high-income country—just fifty are retained in care and only fifty-six achieve viral suppression (US Centers for Disease Control and Prevention 2020a-b). HIV stigma also erodes family and social support, with pernicious negative mental health consequences, from depression and anxiety to diminished self-worth (Remien et al 2019; Orza et al. 2015).

Social determinants of health

Unraveling stigma's layers of complexity requires recognizing that, unlike biological or genetic factors that are not easily modified, stigma, a social determinant of health (SDH), is produced by societies and individuals, and thus, changeable. SDH, "the circumstances in which people live, grow, work and age (WHO 2008, 1), negatively influence health including lack of access to secure employment and education, absence of social, financial protection, and housing and policies that criminalize social groups, such as sexual and gender minorities (Solar and Irwin 2010; UNAIDS 2020a). Importantly, SDH, like stigma, compound existing social and economic disadvantage for excluded groups who are typically already at higher risk of exposure to disease due to environmental and social factors. Hence

SDH further magnify the social and economic consequences of ill health for vulnerable populations (see Diderichsen, Evans, and Whitehead 2001, Figure 1, 15). SDH are responsible for most health inequities (Solar and Irwin 2010; see Anand, Peter and Sen 2004). It doesn't have to be this way. Since health inequities are underpinned by social causes, by definition, they are viewed as avoidable, unfair, unjust, and capable of being altered, through evidence-informed, long-term policies and interventions (WHO 2013; Braveman and Gruskin 2003).

Knowledge gaps

The extant stigma literature is rich, multi-disciplinary, and evolving. Scholars have, however, highlighted particular gaps, including two relevant to this work. First, stigma researchers, especially in North America and Europe, have overlooked its moral, cultural dimensions (Yang et al. 2007). In settings like the Southern United States, HIV stigma can be fully stitched into the social fabric in ways that are not fully appreciated. In Mississippi, the state with the highest HIV-related mortality and poverty rates among all states (Reif et al. 2019), one man with HIV portrayed the stigma that was typically enacted by others:

[H]ere in the state of Mississippi if a person knew that you were [HIV] positive, of course they're gonna feel some type of way, you know?...They gonna be like, 'Don't sit next to him or don't drink by him or eat by him, or ... don't let my kids play with him' (Sprague et al. 2019, 8).

As this participant conveys, stigma bars individuals with HIV from taking part in activities that hold social meaning across cultures such as eating with family and friends. These

Fig. 1 A scene from *Metamorphosis* at the Linbury Studio, Royal Opera House, London, 2011. Published with the permission of *The Guardian*/Tristram Kenton/eyevine/Redux

“everyday” human interactions—cherished rituals—“matter greatly” as Kleinman stresses (2004, 269–270). Indeed, they form the foundation of our local, social worlds. The value we all place on such every day encounters became magnified during the coronavirus-19 (COVID-19) lockdowns. Similarly, the isolation and loneliness generated by stigma corrodes moral, social experience for those living with HIV, including “what matters most”: love, connection, being and doing what one values and desires (Yang et al. 2007, 524). Stigma ultimately threatens the ability of individuals to construct lives they have reason to value, undercutting their human development and capabilities (Sen 1999).

In a second lacuna, researchers have cited the need to investigate how HIV stigma is embedded in healthcare settings by considering attitudes and behaviors of HIV physicians who have a therapeutic alliance with their patients (Geter, Herron, and Sutton 2018; Weiss et al. 2017; Hoffart et al. 2012). In one qualitative study we conducted to understand why people in Alabama delay or lapse antiretroviral therapy, a participant living with HIV stated he had switched doctors because “the other doctor wouldn’t touch me. He wouldn’t touch my body” (Sprague and Simon 2014, 9). In generalized epidemics in Southern African countries, public adverts, television and workplace programs routinely prompt individuals to know their HIV status—making HIV information publicly accessible (George and Sprague 2011; South African National AIDS Council 2017). In contrast, in concentrated HIV epidemics like in the United States and Canada, HIV guidance typically comes from specialist providers: placing emphasis on the relationship of trust forged between a person living with HIV and a physician or nurse. HIV stigma, when experienced by patients during the clinical encounter, can have inestimable, detrimental consequences, since individuals must maintain continuous HIV care throughout their lives (Geter, Herron, and Sutton 2018; Reif et al. 2019).

An uncharacteristically blunt press release by the US Centers for Disease Control and Prevention underscored the continuing high burden of HIV among black and Latino sexual minority men in 2016: “If current HIV diagnoses rates persist, about 1 in 2 black men who have sex with men (MSM) and 1 in 4 Latino MSM in the United States will be diagnosed with HIV during their lifetime” (1). These data imply that unless there are concerted efforts to arrest new HIV infections among black and Latino MSM, high incidence and pronounced race- and ethnicity-based HIV-associated inequities will continue, even as physicians and nurses continue to treat HIV in their patients.

In US clinical settings, factors associated with stigmatizing attitudes, beliefs and behaviors towards those with HIV were gender, race, religion, and provider category: stigma was found primarily among white, male, primary care physicians and clinical providers with no or limited HIV stigma training in the past twelve months—emphasizing a role for greater HIV education and training among providers and health professionals in training (Geter, Herron, and Sutton 2018; Frain 2017). Systematic reviews also underscore the need for greater attention to sexual health and sexual and gender minority health in the curriculum of student health professionals. A review of clinical education in the US found that 44% of all medical schools “may have no formal curriculum in sexual health at all” (Rubin et al. 2018, 1415).

Notably, US physicians and nurses in training represent a new generation of leaders in the medical health professions who will, in turn, shape the institutional cultures, norms and practices of health settings and staff. In recent years, divisive socio-political discourse and growing social inequalities have increasingly been documented, globally (World Economic Forum 2017). In the US, social divisions reached a fever pitch

in 2020, following the shocking killing of George Floyd, an unarmed black man, at the hands of police. At the same time, race-based health inequities—long evident for those with HIV—were pushed to the foreground during the COVID-19 pandemic (Egede and Walker 2020). Health and clinical settings mirror social settings. Adverse social attitudes and norms can be reinforced or contradicted by individuals in health facilities (Hay et al. 2019). The need for educational curricula responsive to health inequities and social justice is therefore crucial: hence the focus on this cadre and health settings as a location of intervention vis-à-vis HIV stigma. If stigma is socially produced by individuals and modifiable, then it is crucial to ascertain: what types of interventions and educational curricula, including literature, are effective at advancing greater understandings of HIV stigma in health settings?

The role of empathy in HIV stigma

One pathway to address and reduce stigma may be through empathy. Some studies indicate that a lack of empathy may predict HIV stigma; and conversely, empathy may reduce HIV stigma (Nyblade et al. 2020; Batey et al. 2016; Lin et al. 2012). Notably, there is no consensus on definitions for empathy in the literature; it is a subtle, complex construct to operationalize with many studies relying on self-reports—posing challenges to the validity of research on empathy (Kelm et al. 2014; Batt-Rawden et al. 2013). With those provisos, many researchers increasingly agree that empathy is an umbrella term having at least three components, one I adopt here (Weisz and Cikara 2020).

First, empathy has an affective aspect, also called *experience sharing*, where people feel the states of others, vicariously, though not to the same degree. Second, there is a cognitive component associated with empathy, called *theory of mind or perspective-taking*, where individuals are able to consider the experiences and thoughts of others. Third, the motivational component of empathy, often characterized as *compassion*, reflects prosocial behaviors that prompt people to reduce the suffering of others, including strangers (Weisz and Cikara 2020). Warranting emphasis in the debates about empathy is this: empathy is an engine for prosocial goals. The three components of empathy are associated with higher relationship satisfaction, better health, increased emotional wellbeing, caring for children, coordinated action toward group goals, better team performance, higher employee satisfaction, and higher occupational commitment (Weisz and Cikara 2020). But empathy has its limits. Studies are mixed but research indicates that empathy declines during medical training and residency, as physicians begin routine patient care (Thirioux, Birault, and Jaafari 2016; Chen et al. 2012; Neumann et al. 2011).¹

Of significance, alongside ongoing debates about empathy, the Association of American Medical College guidelines continue to locate empathy at the center of its expectations of physicians, stating: “Physicians must be compassionate and empathetic in caring for patients, and must be trustworthy and truthful in all of their professional dealings” (1998, 4). Training in empathy for health professionals and students has been found to be efficacious in a meta-analysis of nineteen randomized controlled trials (Teding van Berkhout and Malouff 2016). Systematic reviews continue to document the importance of empathy for patient care and outcomes. Moreover, provider empathy has been associated

with reduced patient anxiety (Weiss et al. 2017); higher medication self-efficacy among patients (Cohn, Moore, and Beach 2016); and—despite the absence of consistent outcome measures—even clinical outcomes (Kelm et al. 2014); one systematic review concluded: “empathy delivers significantly better clinical outcomes” (Derksen, Bensing, and Lagro-Janssen 2013, e76).

Markedly, findings among patients with HIV similarly underscore the role of provider empathy (Flickinger et al. 2016). Patient satisfaction with care has been associated with improved HIV care retention, adherence and outcomes (measured as viral suppression) in studies conducted in high-income countries (Dang et al. 2012). In systematic reviews, the most important aspect of health care for those with HIV (signifying satisfaction) was the patient-provider relationship, encompassing: trust, empathy, professionalism, provision of emotional support—and notably—taking an interest in patients’ personal relationships and comfort discussing personal issues (Cooper et al. 2016). Moreover, in some studies, the patient-provider relationship far exceeded other factors (Dang et al. 2012).

To underscore the point: those living with HIV, often part of socially marginalized or devalued groups, face numerous obstacles to achieving optimal HIV outcomes, with stigma compromising care and wellbeing (US Centers for Disease Control and Prevention 2020a-b; Reif et al. 2019). The evidence indicates people living with HIV value, not only quality of care, but the quality of relationship with their providers: those who demonstrate empathy and show interest in their lives, including social determinants that influence their opportunities to be healthy and to engage in ‘what matters most’ (Yang et al. 2007, 524; Okoro and Odedina 2017). In understanding the complexities of HIV stigma, both the problem and response, it is necessary to ask: if stigma precludes optimal HIV outcomes and wellbeing, are stigma reduction interventions, including educational curricula, effective in overturning or reducing stigma in health settings?

Stigma reduction interventions, empathy and their effectiveness

The evidence indicates that interventions to curb HIV stigma and discrimination have been found to be effective in health and other settings (e.g., education, workplace, community). Interventions are a cluster of structured activities aimed at achieving change at specific levels, with identified outcomes and measures. In the context of HIV-related stigma, structural approaches are necessary and they encompass activities to reduce or abolish the structural factors that influence stigma at differing levels, including laws and policies that institutionalize unfair treatment or discrimination of people with HIV (Stangl et al. 2013). Taken together, this comprises a whole of society approach that works upstream to engage with social-economic structures and downstream to provide HIV treatment, prevention, care and support, while ensuring human rights and dignity in health settings. As part of this approach, the clinic thus needs to be seen as one location, or sphere of intervention, among overlapping spheres (countries with generalized HIV epidemics employ this approach through their multi-stakeholder national strategic plans, see South African National AIDS Council 2017).

In 2020, UNAIDS documented twenty effective interventions to reduce HIV-related stigma and discrimination in healthcare settings, including training student physicians and nurses across low-and-lower-income (Ghana and Tanzania), upper middle-income (South Africa) and high-income settings (Canada, the US and China) (see UNAIDS 2020a, Annex 4, 75-76; Nyblade et al. 2020; Batey et al. 2016; Li et al. 2013; Lin et al. 2012). Strikingly,

empathy building was rooted within the intervention approach and methods. For example: “Participatory trainings of facility staff use discussion and self-reflection to build empathy and reduce distance (contact strategies)” (Nyblade et al. 2020, S96). In another, empathy was measured using the Jefferson Scale of Physician Empathy (Lin et al. 2012; Hojat et al. 2002). In a third, measures for provider participants included empathy, HIV knowledge, and perceived risk (Batey et al. 2016, 521). These HIV-related interventions aimed to do more than cultivate empathy, however. They sought to increase knowledge, inform the beliefs and attitudes of health professionals, and change the culture of health facilities (Nyblade et al. 2020). Factors identified as essential components of the interventions’ effectiveness were: multi-methods; reliance on participatory approaches, including participatory training; institutional support and leadership (including budgeting); and, especially, contact with and discussions of participants with those living with HIV (see Batey et al. 2016; Nyblade et al. 2020).

These stigma reduction interventions made no mention of literature or the arts (UNAIDS 2020a). Nonetheless, in medical training curricula, educators and scholars have long-viewed art, literary texts, and narrative as pedagogical tools that enable readers to “gain empathy and compassion for human suffering,” among other functions (Kottow and Kottow 2002, 41; Krishnasamy et al. 2019; McDonald et al. 2015; see Hunter 1991). Indeed, the recognition of the literature-health-medicine nexus, and the role of literature to inform readers’ understandings of health and ill health, remains a cornerstone of the medical health humanities (see Jones, Wear and Friedman 2018, 1-9; also Whitehead et al. 2016. For other seminal perspectives on the role/s of literature in medical health education, see Jones 1999; Evans 2003; Hawkins and McEntyre 2000; for the role of the arts in medicine, see Scott 2000.) The medical/health humanities have engaged with HIV and AIDS over the years in crucially important ways that have illuminated and reshaped knowledge and understanding of key constructs, relationships and concerns (O’Connell 2020; Hutchinson and Dhairiawan 2017; Tomso 2010; Farmer 2001; Hawkins and McEntyre 2000). Some of the most explicit discussion of the role of the medical health humanities and HIV, as well as themes related to social constructions of illness, have emerged most recently from South Africa (Tsampiras 2020; Pentecost et al. 2018; Reid 2014). Performative theatre, plays, and art have also been mobilized to powerfully depict the experience of those living with the virus (see Jones 1994). In this way, stories, art and film have long been used to “enhance empathy, perspective-taking, and openness to otherness” both in medical education curricula (Kumagai and Wear 2014, 973)—and in the case of HIV—to deepen public awareness.

There are robust, wide-ranging and persistent debates about empathy among intersecting literatures, spanning: the challenge of achieving “sustainable empathy” in patient care and outcomes (see Zaki 2020, 459); factors associated with empathy’s decline among providers (Chen et al. 2012; Thirion, Birault, and Jaafari 2016); interventions to cultivate empathy in medical health curricula among both physicians (Kelm et al. 2014) and students, including use of narrative medicine and literature to increase empathy (with differing results) (Krishnasamy et al. 2019; Patel et al. 2019; McDonald et al. 2015; Yang and Yang 2013). There is also a critical literature on empathy from the perspective of medical health humanities (see Garden 2007), including a recurring critique that the burden to build empathy should not be thrust onto the shoulders of the medical health humanities (for discussion, see Jones, Wear, and Friedman 2018, 1-4). Additionally, some have stressed empathy’s role in leading to more ethical health care and enhanced wellbeing for physicians themselves (Kelm et al. 2014).

On their own, arts and literature would not be sufficient to serve as anti-stigma interventions targeting HIV stigma at the structural level. They continue to play a crucial role in medical health education, however, and when combined with other intervention activities, may influence participants in profound ways (Marchalik and Jurecic 2015; Hawkins and McEntyre 2000). Literature can be part of larger efforts within medical health education curricula to overturn health inequities and inform student understandings of social forces and determinants that shape people's health behaviors, constraints, and opportunities to be healthy. Growing empirical research has found that reading narrative fiction affects our emotions prior, while, and after reading, shaping our experiences in powerful ways. Once evoked, our emotions affect our experience of the narrative, influencing our cognitive processing in ways that may "prime" our experience in the real world (Mar et al. 2011)—thus also creating the conditions for exploring the intersection of social-structural factors, including class, race, gender, income, and identity. Increasing experimental evidence indicates that reading literary fiction enhances theory of mind tasks associated with empathy (Kidd and Castano 2013). To add to the impetus, in 2018, the US Board on Higher Education and Workforce of the National Academies of Sciences, Engineering and Medicine conducted a study that reviewed the evidence underpinning the assumption that educational programs that "mutually integrate learning experiences in the humanities and arts with science, technology, engineering, math, and medicine (STEMM) lead to improved educational and career outcomes for undergraduate and graduate students" (2018, xii). The committee found sufficient compelling evidence to recommend this integration, stating that: "further effort be expeditiously exerted to develop and disseminate a variety of approaches to integrated education" (xii). Such an integration of STEMM, arts and humanities requires embracing a pedagogical shift in valuing knowledge from the medical health humanities, and in the materials and methods used to inform student learning. What materials may enhance greater critical discussion and understandings of HIV stigma's sociological processes among students in the medical health sciences, including reflection on the role of empathy and its absence towards those who experience HIV stigma?

Enter Kafka In 2016, as part of an academic residency, I was writing up findings from empirical HIV research on women in South Africa, a principal focus of my work as a social health scientist for over fifteen years. The corrosive mental and physical health effects of stigma in this population, like other populations elsewhere, were clear (Sprague 2018; Orza et al. 2015). Yet stigma's power still seemed to escape full expression, including in my teaching of students in the health sciences. Accustomed to reading literature in the evenings, I spied a book in the Bellagio Center's well-stocked library I had long wanted to read. That slim volume, Kafka's *Metamorphosis*, even seemed to whisper, 'choose me.' I devoured it that night. One of the acclaimed works of the 20th century (Strauss 2016), Kafka's compact forty-seven-page novella seemed to convey a more effective depiction of stigma than any academic research I had read or generated, sparking this inquiry. I investigated: how might Kafka's *Metamorphosis* reveal greater insight into the process and experience of HIV stigma? And what are the implications for medical health education, if any?

Before presenting the original themes derived from my analysis, I foreground selected, primary themes from the extant literature, briefly highlighting (a) Kafka's background and its influence on *Metamorphosis*, followed by (b) scholars' reading of the text, particularly its (c) use in medical health education, with emphasis on dominant concerns and gaps.

Kafka's *metamorphosis* in the medical health humanities

Set in Prague and published in 1915, *Metamorphosis* confounded critics then, as today (Cronenberg 2014). Our protagonist, Gregor Samsa, wakes up in his bed at the start of a new day, having been converted into a giant ‘bug’ (*wanze* in German) during the night. Gregor is a traveling salesman, and the family, middle class (Kafka 2016, 3, 22, footnote 4). Attention to *Metamorphosis*, Kafka's brief “masterpiece” and his other works, reflect the recognition by scholars, whether of political and social criticism, religion, philosophy, psychiatry or literature, that Kafka's work is “inexhaustible,” (Strauss 2016, 129). Numerous scholars, studying *Metamorphosis*, “have tried to get at its heart and soul, only to be followed by others, similarly dedicated and agile, yet anxious to recommend a quite different angle” Coles remarks (1995, 306–307). Hence, Cole counsels: “There is no point trying to figure out *the* explanation for this...powerfully affecting story” (306). One can almost hear Kafka laughing in the distance as I tap out this sentence.

Kafka's works plumbed themes that were reflected in his own life (1883–1924) and social world (Strauss 2016). *Metamorphosis* can be read as a satire on the stifling aspects of a conventional, capitalistic life (Rowe 2002). Kafka lived this life: making his earnings as a lawyer by day, while writing diligently, even obsessively, by night (Pohland 2000). During Kafka's time, German cultural values were shifting toward conformity with authoritarianism, as images of honor, strength, and virility came to define “civic virtue and social value” (Pohland 2000, 234). Within this historical period, theories of eugenics, social Darwinism, authoritarian hygiene and control of disease were taking hold (Pohland 2000). Importantly, these ideas were infusing Kafka's views towards disease in his writing. Through illness and otherness, Kafka's texts probe understandings of self that fail to conform with the rational, scientific order of the day, but rather “transgresses” those understandings, emphasizes Pohland (2000, 233). This includes Kafka's treatment of tuberculosis (TB) even before he contracted it. At the time, TB, or consumption, altered—from being viewed as “a signature of heightened spirit, sexuality, and individualization, even genius—to instead become increasingly stigmatized” (Pohland 2000, 234). TB would eventually claim Kafka's life when he was just forty-one.

Kafka was also plagued by depression and anxiety (Abbasian 2007), references to which punctuate his letters. Writing to fiancée, Felice (they never married), while drafting *Metamorphosis*, Kafka reveals his struggles to write, penning his feelings about the story and protagonist Gregor: “a short story...occurred to me in bed in my misery, and now troubles me and demands to be written” (2016, 52). Continuing to refer to his ‘misery’ in his letter to Felice (dated November 17–18, 1912), Kafka bemoans his battle to write *Metamorphosis*: “Not a line of the novel has been written today and I go to bed tonight with little enthusiasm” (52).

Kafka expresses his feelings for Felice, his depression and his protagonist's sad plight:

Dearest, oh God, how I love you! It is very late at night. I have put aside my little story...it is a little frightening. It is called *Metamorphosis*...I am thoroughly depressed at the moment, and perhaps I shouldn't be writing at all. But my hero's story has also had a very bad time today, and yet it is only the last lap in his misfortune, which is now becoming permanent. (53)

That *Metamorphosis* has become a *core* text in medical/health humanities education for more than four decades can be attributed in part to its salience as a teaching tool (Flood and Soricelli 2018; Kumagai and Wear 2014). This salience is multi-faceted. Central to its appeal as a text for medical practitioners seeking to better understand their patients—and themselves who might eventually *become* patients—stress Taran and Detsky, lies in the novella's ability to mimic all of the uncertainty of illness. Gregor:

is a stranger to the very process that undoes him. Similarly, for patients, living with disease may be...a battle where the enemy's next move can never be predicted. Disease therefore remains for most people a shape-shifting foe. (Taran and Detsky 2018, 753)

Scholars have written, too, that the work is able to nimbly capture the signal experiences of neglect, dehumanization, ambiguity, and of seeking meaning through illness and suffering (Flood and Soricelli 2018; Kumagai and Wear 2014). Strikingly, some of this suffering is created by social norms and expectations. Even prior to his conversion into a large insect, Gregor has become alienated from his essential self through his soul-thrashing occupation (Flood and Soricelli 2018). Gregor is a salesman operating in an utterly exhausting profession but what Gregor has actually sold is himself, as Bernofsky notes (quoted in Kafka 2016, xvii).

In *Metamorphosis*, Kafka invites an examination of the purpose of life, Coles (1995) emphasizes. Rowe presses the point, stressing what he sees as Kafka's sweeping intent: *Metamorphosis* also carries a warning message for humanity, one particularly appropriate for medical practitioners. Rowe cautions: "It represents a challenge to the notion of a shared humanity and solidarity that accepts an obligation to protect its most vulnerable members, including those with life-threatening illness" (2002, 278).

In addition to the vulnerable among us, Kafka asks us to consider the status quo, the price of alienation—not only Gregor's transformation into death, but as his family represents, our continuing experience as survivors. In other words, "do we profit handily from the human degradation of others?" as Coles puts the question (1995, 310–311). While some writers argue that Kafka's text evinces a grim view of humanity, others like Rowe view the work differently (see also Evans 2003; Abbasian 2007). He writes: "Our humanity is not a given. It can wear away. We maintain it by drawing on structures that nourish it and undertaking conscious efforts that may help to keep the milk of human kindness flowing" (2002, 279).

In this manner, again, the novella forces each of us to take a long look at ourselves "at what we are and what we might become" Coles writes (1995, 311). Kumagai and Wear observe, in this manner, literature and the arts play a crucial function of troubling one's assumptions, to view the self and the world in fresh light (2014). The resulting 'estrangement' (a term employed by Russian author Viktor Shlovsky, who used it to refer to the structure of narrative) can create a disruption that allows for dialogue on biases, while also breaking open the opportunity for bearing witness, the authors stress (Kumagai and Wear 2014).

Strikingly, while some work explores different stigma types in *Metamorphosis*, such as the stigma of mental illness, as well as alienation and neglect (Abbasian 2007; Antony 2017; Pohland 2000; Kumagai and Wear 2014; Flood and Soricelli 2018), I could find no work that analyzes the relevance of *Metamorphosis* to HIV stigma in any detail. This work is situated within that aperture.

Themes

In Act I, Kafka lays the essential groundwork to establish the plot line and accompanying themes that unspool over the story's course. Two primary themes resulted from the analysis of the textual data: *What is at stake* and *stigma as an intersubjective process*. I present the story as a five-act play, to categorize the drama as Kafka tells it.

Act I. The change

Gregor Samsa awakens in the early morning, having been transformed into a large insect during the night. Gregor's household includes his father, mother and seventeen-year old sister, Grete (Kafka 2016, 3, 22, footnote 4).

Theme 1. What is at stake

Stigma as a social process begins unfolding in Gregor's household following Gregor's transformation into an insect. Alongside his physical change into a beetle, Gregor's valued identity within the social hierarchy will soon be lost. Gregor is the family's sole breadwinner: a role he cherishes. Kafka makes it clear that Gregor had stepped in to occupy the role of economic provider, after his aging father's ability to work had been compromised: "Gregor's father...was old and hadn't worked in a full five years,...he was supposed to avoid overtaking himself" (23).

As the story opens, the centerpiece of the drama hinges on the threat of a new financial crisis engulfing Gregor's family. Avoiding this cataclysm is Gregor's chief aim. It underpins the urgency of Gregor's need to get out of bed and catch his train to work. Problematically, however, when Gregor awakens encased in the shell of an insect in the wee hours of the morning, his legs have become like a millipede's. Despite his attempts, he cannot get them to work in concert to get out of bed: "I've got to get up, my train leaves at five!" (4).

Gregor's central preoccupation becomes evident: "His only concern had been to do everything in his power to let the family forget...the mercantile catastrophe that had plunged all of them into a state of utter hopelessness" (22). In the context of the family's economic pressures, Gregor had worked: "with particular zeal and risen almost overnight from petty clerk to salesman...[where] he had a quite different earning potential" (22). Kafka puts a spotlight on Gregor's role in rescuing the family's fortunes: "his sales commissions...were immediately transformed into cash that could be plunked down on the table at home, before the eyes of his astonished, delighted family" (22).

The threat of job loss, and by implication, the family's impecuniousness, is the sword of Damocles suspended over the heads of the family. In his transformation from human to insect, Kafka enunciates a series of losses. He sketches the social and economic world in which Gregor and his family are situated. He communicates the power relations at work in Gregor's life and household, which remain similar to today's. The occupational hierarchy is organized as a form of social control against which Gregor chafes: "As soon as I've saved up enough money to pay back what my parents owe him—another five or six years ought to be enough—I'll most definitely do that" (4).

Kafka limns a working world where the pressures of employment loom large for the family. Gregor bemoans his bondage to his employer: "If I didn't have to hold back for my parent's sake, I'd have given notice long ago—I'd have marched right up to him [his boss] and given him a piece of my mind" (4). He ponders: "What if he called in sick?"

But that would be mortifying and also suspicious, since Gregor had never once been ill in all his five years of service” (5). Gregor reflects on his certain absence from work: “No doubt his boss would come calling with the company doctor [who] would reproach Gregor’s parents for their son’s laziness” (5). Astoundingly, Gregor’s boss does appear at his home, heightening the drama. Gregor remarks on the embarrassment of having his boss descend on his parent’s home: “Did the general manager have to come in person, and was it necessary to demonstrate to the entire innocent family that the investigation of this suspicious matter could be entrusted only to the general manager’s sharp intellect?” (8).

Depicting a world dominated by brutishness, Gregor refers to the overlords of industry to which he is indebted, lamenting: “Why oh why was Gregor condemned to serve in a firm where even the most negligible falling short was enough to arouse the greatest possible suspicion?” (5).

The lack of trust of employer in employee, the miserly attention that must be paid to time, to the very seconds ticking by, and the heavy yoke of the work contract, is embroidered into the story. The reader gains a sense that Gregor’s very soul is at risk, a hallmark of Kafka’s work, which reveals his concern with the human condition, including loss of human freedoms and dignity—highly relevant to those with HIV (Strauss 2016, 131):

Was every last one of the firm’s employees a scoundrel, was there not a single loyal, devoted soul among them who would be driven mad by pangs of conscience should he fail to make the best possible use of even just a few morning hours for his employer’s benefit? (8)

Gregor’s boss shouts invectives through the closed door of Gregor’s bedroom, demanding Gregor come out of his room and provide an explanation for his absence at work:

I must ask you for a clear and immediate explanation. I am astonished, utterly astonished. I’ve always known you as a calm, sensible person, and now it seems you’ve begun to permit yourself the most whimsical extravagances. (10)

Continuing his accusations, his boss shouts to Gregor through the door:

What has come over you? You barricade yourself in your room, you reply to queries only with yes and no, you cause your parents onerous, unnecessary worries, and you are neglecting—let me permit myself to note—your professional responsibilities in a truly unprecedented manner. (10)

Here, the manager is blaming Gregor for his illness or altered condition, just as those living with HIV are blamed for acquiring the virus (Earnshaw and Chaudoir 2009). By the end of Act I, Gregor’s very identity as sole provider, his social and economic standing, and the family’s income, is diminishing. Kafka communicates that while Gregor’s physical form has already morphed from one form (man) to another (beast), this will quickly be matched by his social devaluation. Strikingly, Gregor’s changed physical appearance has not made him frightful to himself, initially. Rather, he is merely curious (though this will change). Kafka casts his family—mother, father, and sister—into particular roles within the social hierarchy. These have the most influence on our protagonist’s internalization of stigma, where stigma informs his sense of self, his anticipation of stigma (see Earnshaw and Chaudoir 2009; Pantelic, Sprague, and Stangl 2019), and his ultimate end. It is indeed in ‘relation’ with others that Kafka punctuates the effect of Gregor’s conversion into an

‘other’, i.e., separating those who are devalued by virtue of their condition, diagnosis, or other attribute, from the general population (Link and Phelan 2001, 370–371).

Gregor’s mother is initially loving and protective, defending Gregor to his boss: “I’m so glad you paid us a visit, sir...we’d never have managed to persuade Gregor to open up... surely he isn’t well, even though he denied it this morning” (9). Frau Samsa continues: “[He is] not well at all, take my word for it, sir. Why else would Gregor miss his train! The office is the only thing that boy ever thinks of” (9). Through the door of his bedroom, Gregor appeals to his boss for fairness and humane treatment, on behalf of his parents: “Sir! Do be gentle with my parents. The allegations you make are unfounded....I’ll be back on the road in time for the eight o’clock train” (11). In response to Gregor’s appeal, the manager is alerted to his very strange voice: the voice of a beast. His boss reacts with stunned disgust, asking the Samsa family: “Did you hear him speaking just now? That was an animal’s voice” (11). Next, Gregor scuttles out of his bedroom, showing himself as a large arthropod for the first time.

Act II. The boss makes haste

The reaction of his boss and family to Gregor-cum-beetle is shock and horror. Their collective response further captures the unfolding social process of ‘othering.’ Kafka uses imagery in the form of gestures, actions and reactions, rather than dialogue, to relay the full potency of his boss’s response to Gregor’s change: “[the manager] pressed his hand to his open mouth, slowly retreating, as though being driven back by an invisible, steady force” (13).

Theme 2. Stigma as an intersubjective process

In the second theme, as Gregor’s beetle body becomes fully visible to his family and boss, the intersubjectivity of stigma as a social process and construction also becomes manifest. Stern defines intersubjectivity as: “the capacity to share, know, understand, empathize with, feel, participate in, resonate with, and enter into the lived subjective experience of another” (2013, 78). Yang and colleagues elaborate the intersubjective nature of stigma:

much of stigma occurs in the inter-subjective space *between* people at the level of words, gestures, meanings, feelings, etc., during engagement with what matters most... By taking place both outside and inside a person, stigma is a social and subjective process. Thus, stigma can be viewed as interpersonal, or relational in nature. (2007, 524)

In a show of fear and disgust, Gregor’s boss turns away, “his mouth contorted” (13). Kafka enunciates his rapid retreat:

to judge by the abrupt motion with which he [his boss] withdrew his foot from the living room... one might have supposed he’d just burned it...Having reached the vestibule...he stretched out his right hand, gesturing broadly in the direction of the stairs...as if some all but supernatural salvation awaited him there. (14–15)

Kafka then sharpens the contrast between Gregor as man and Gregor as insect, like a dimmer switch he is rotating to the brightest setting: Gregor catches sight of a framed photo of his former self. He is in his military garb, with his “carefree smile...he rested his

hand on his dagger...[he] commanded respect for his bearing and his uniform” (14). In that moment, the photo serves to magnify the extent of Gregor’s change and accompanying loss: from proud, esteemed soldier in control of his fate, to an insect that incites horror in his intimate circle. Gregor, hoping to salvage the situation, decides to reason with his boss. His job was at stake! He crawls in the manager’s direction, out to the living room. The boss is now gripping the banister in fright: “The General Manager...looked back on the scene one last time...and leapt down several steps at once and vanished. And the cry of horror he gave as he fled resounded through the stairwell” (16). His mother’s reaction enunciates the full magnitude of Gregor’s change: “[She] leapt high up into the air...crying out to be rescued from the advancing beetle, ‘Help me, for God’s sake, help!’” (16). Here, too, readers gain the first real glimpse of Gregor’s father. Herr Samsa tries to control the situation by seizing the manager’s walking stick. He waves it at his son, ominously:

“[He] set about driving Gregor back into his room with a great stamping of feet, brandishing both newspaper and stick... making hissing noises” (16).

As Gregor is being pushed back into his bedroom, the undercurrent of violence meted out by father to son is palpable. Gregor tries to maneuver his many legs, but becomes injured:

Scraping his one flank raw and leaving ugly stains behind on the white door... he was wedged tight, unable to move...on one side, his little legs trembling in midair, while on the other they were crushed painfully beneath him. (17)

His father: “administered a powerful shove from behind...that sent him flying, bleeding profusely, into the far reaches of his room” (17). By the end of Act II, the gestures, words and interactions aimed at Gregor by his boss and family are grounded in fear and disgust in what he has now become, mirroring stigma experienced by those with HIV.

Act III. Gregor becomes a patient

Banished from the living room, Gregor will become a captive of his bedroom, and increasingly isolated from his family’s companionship. Over time, in yet other hallmarks of HIV stigma, alienation and self-blame will dominate. Notably, Gregor’s psychological state, which had remained quite hardy to this point, will deteriorate. Kafka further highlights Gregor’s physical changes and the intersubjectivity of stigma, using the actions and reactions of sister Grete:

[Grete] opened his door and cast an anxious glance into his room. She didn’t immediately spot him, but when she noticed him beneath the settee...the sight so alarmed her that, unable to control herself, she slammed the door. (19)

Initially caring and attentive, Grete marks the reduction in Gregor’s status—from provider to dependent. She enters “as though she were entering the room of a gravely ill patient or even a stranger” (19). Similar to those with HIV whose family members require them to use separate utensils (Sprague et al. 2019), Grete avoids touching the food Gregor has eaten. She picked up the spilled milk: “not with her bare hands, to be sure, but with a rag” (19). Gregor observes and absorbs Grete’s disgust: “[she] used a broom to sweep up not only the remains of his meal but also the food he hadn’t even touched, as if these items too were no longer fit for consumption” (20).

Gregor's view of himself as a burden intensifies. He wants to shield his family from suffering on his account. Gregor has been converted into a disgusting, 'other', excluded from the family. His very presence reduces the family's freedoms and mobility: "no one wanted to remain alone in the house with Gregor...[yet] the house could not be left unattended" (21). With Gregor unemployed, every family conversation centers on economic concerns. Gregor's shame at no longer occupying the provider role is pronounced: "Whenever the family...spoke of the necessity of someone earning money, Gregor would let go of the door and throw himself down upon the cool leather sofa beside it, burning with shame and sorrow" (24). Sadness preoccupies Gregor, precluding sleep: "He would lie there the entire long night, not sleeping for a moment, just scrabbling for hours against the leather" (24). Gregor's change is characterized as the greatest calamity of the family's lives:

The main thing keeping the family from moving to a new apartment was their complete sense of hopelessness...they had been struck with a misfortune, such as no one else in their entire circle...had ever experienced. (34)

He is increasingly anxious about the burden he has created for his loved ones: "If only he had been able to speak to his sister and thank her for all she was compelled to do for him, he would have found her ministrations easier to bear; as it was, he suffered beneath them" (24). Gregor has depressive thoughts: "[E]ating had soon ceased to give him even the slightest pleasure. Gregor now ate almost nothing at all" (36).

Grete starts changing, becoming less interested in Gregor's welfare. Instead, she belittles Gregor. Because Grete is horrified by his bug-like appearance, Gregor takes steps to hide himself, illustrating the anticipation of stigma (Earnshaw and Chaudoir 2009). Gregor begins to view himself with self-loathing, also revealing the internalization of stigma:

[Grete]...discovered him, motionless and propped upright as if for horrific effect...started in alarm and shut the door...Gregor naturally went and hid himself away beneath the settee.... he understood that his appearance was still unbearable to her. (25)

Act IV. Gregor must disappear

With good intentions, mother and sister decide to move the furniture out of Gregor's room so that he can roam freely, "crawling back and forth across the walls and ceiling" which prompts a crisis (26). By removing his belongings, Gregor is losing his connection to his old self—thus becoming even more alienated from his humanity. As he watches mother and sister in hiding, careful not to alarm his mother, Gregor reflects longingly on these symbols of his old self: "They were clearing out his room; taking...all that was dear to him...the desk at which he had written his homework assignments as a...pupil" (28). Gregor "burst out of hiding" in protest (28), but Gregor's mother was still not accustomed to his appearance, shrieking: "'Oh God, oh God!'" and [she] fell back...her arms spread wide" (29). Gregor, again, blames himself: "his mother...was possibly on the brink of death, for which he himself was to blame" (29). Consumed by anxiety, Gregor is "tormented by his worries and self-reproach (30). Gregor tries to crawl after and comfort his mother but his father intervenes—again with violence: "his father had decided to bombard him...[hurling] one [apple]...[it] embedded itself in his back. Gregor...felt nailed to the spot and collapsed there" (31). Gregor is now mortally injured, his spirits at their lowest ebb: "The grievous wound Gregor had received...cost some of his mobility, probably for good... now he must hobble across the room like an old invalid" (32).

After this, Gregor, feeling helpless, is plagued by self-blame. His wound aches. He falls into a deeper depression, seeming to deliberately starve himself, much like those with HIV who internalize stigma, punish themselves for their HIV serostatus (Earnshaw and Chaudoir 2009): “Gregor now ate almost nothing” (36). Becoming isolated from social contact, Gregor spends hours lying listlessly in the darkest corner of his room. He observes his own decline. He realizes his end is near: “I am wasting away...It seemed...as if it [his body] was gradually becoming weaker and weaker, and in the end would fade away altogether” (43).

The family argue over Gregor’s fate. Grete insists that Gregor “must disappear”—that the family cannot bear the burden of Gregor, the patient, any longer. Gregor, too, decides he must disappear (43). Gregor’s final reflections are of his love for his family and his desire to relieve their burden: “He thought back on his family with tenderness and love” (43).

Act V. A new life begins

The next morning, a maid finds Gregor unmoving in his room. She tries to tickle him with a broom to no avail: “she gawked in surprise...flung open the door of the bedroom and in a loud voice shouted... ‘Come have a look, it’s gone and croaked—just lying there dead as a doornail!’” (44). In turn, Herr and Frau Samsa “shot upright” (44): “[They] first had to recover from their shock. ‘Dead?’ Frau Samsa asked.... By way of proof, [the maid] pushed Gregor’s corpse...to the side with her broom. Herr Samsa said, ‘now we can thank God’” (44).

Kafka portrays the family’s palpable release from the burden of managing Gregor as freedom and possibility, as if they’ve been sprung from prison. Immediately the family take a visit to the country: “all three...left the apartment together, something they had not done for months, and took the electric tram...to the open countryside” (46). Kafka uses the imagery of light to capture the bright future that awaits the family:

The car in which they sat all alone was entirely suffused with warm sunlight. Cozily leaning back in their seats, they discussed their future prospects, and on closer investigation it appeared that these prospects were...quite advantageous....The greatest would be their move to a smaller apartment; cheaper and more convenient than their current one, which had been picked out by Gregor (46).

As we come to the end, Kafka punctuates the transformation by focusing on new possibilities for Gregor’s family in marked contrast with his death: “it seemed to them almost a confirmation of their new dreams and good intentions” (47).

Discussion and implications for advancing understandings of HIV stigma in medical health education

Kafka offers students of the health professions an alternative knowledge paradigm with which to engage HIV stigma. Rather than academic journal articles, the novella becomes the primary vehicle by which to engage stigma as a social construct and determinant of health. Kafka’s economy of words, his humor and rapier-like writing style pull us into the drama from the start. His gift for sketching an entire social world in miniature ignites our

imagination. He disarms our data-driven brains, compelling our curiosity, intuition and engaging our emotions (Mar et al. 2011). For readers who undertake the narrative journey alongside Gregor, Kafka reveals that stigmatization results in substantial losses—fully illuminating ‘what is at stake’ in theme one. The sociological-structural aspects of power and control that enable stigmatization to diminish one’s economic and/or social position and identity are inextricably woven into the unfolding story. Employment becomes reduced or made impossible for Gregor: true for people living with HIV, globally (Sprague, Simon and Sprague 2011; UNAIDS 2020a). Gregor’s social identity and role within the family deteriorates. Indeed, his family’s social standing becomes reduced, relative to their neighbors and friends—producing shame (Abassian 2007; Hutchinson and Dhairyawan 2017).

Via stigma as an intersubjective process in theme two, Gregor undergoes the same othering, blame and rejection that informs the lived experiences of many living with HIV (Orza et al. 2015; Sprague et al. 2019). In Kafka’s narrative text—embracing gestures, actions and responses—readers come to comprehend how stigma is produced and reproduced in the power relationships and social roles that connect Gregor to his boss and family (Link and Phelan 2001; Parker and Aggleton 2003; Yang et al. 2007). Gregor’s family labels him disgusting. They refer to him as a burden that must disappear. They seek to lock him away. Their responses inform Gregor’s self-identity, leading to his internalization of stigma, depression and premature death (Pantelic, Sprague, and Stangl 2019). Readers see qualities of respect, fair and humane treatment replaced by scorn, ridicule, fear, gossip, and horror that Gregor’s new state provoked in others. This characterization perfectly captures how those affected by the virus can be treated (NGO Delegation to the UNAIDS Programme Coordinating Board 2010). Gregor’s travails of becoming an insect and the attendant process of reckoning with his ‘discredited’ self exemplify the social basis of ill health: how social factors like stigma shape the health status, opportunities, choices, behaviors and even outcomes of key populations living with HIV (WHO 2008; UNAIDS 2020a–b). As Gregor is stripped of his humanity, he loses, not only the love and companionship of his family, but his anticipated future: his dream of leaving his job and removing the shackles of his employment, of sending his sister to the conservatory. In this way, for people with stigmatized conditions, desired human capabilities may contract (Sen 1999). Kafka demonstrates that the effects of stigma can be viewed in terms of what matters most: human dignity, respect and esteem from others, love, friendship, health and essential freedoms—including the ability to construct a life one has reason to value (Sen 1999; Yang et al. 2007). To accompany Gregor on his metamorphosis—his alienation from his family, his depression and death—is to bear witness to the full social power of HIV stigma: to feel sadness, pathos, and distress, and to experience social exclusion and dehumanization (Kumagai and Wear 2014).

Metamorphosis also invites students to explore moral, ethical questions. The moral implications of stigma can be felt, observed, and debated by readers as they engage with the novella’s cast of characters, who take on a caricature-like nature for effect, but remain believable, thus generating genuine relatability—even empathy for some. Kafka places Gregor’s world onto the canvas, and through Gregor’s circle, illuminates moral, social experience and how stigma can be shaped, circumscribed or extended by us all. Importantly, the text can ground readers in a conversation about alternative endings and realities. We could be Grete, the General Manager, Frau or Herr Samsa. A social construct, HIV stigma *can* be disrupted. Gregor’s family could act differently. Just as families surprise individuals living with HIV—embracing them with love, and yes, empathy. By illustration, one participant in Mississippi anticipated HIV stigma from his family, which was not experienced, stating:

It surprised me a whole lot because I thought I would get rejected. And I didn't... when I go to my family, they didn't care what I had [referring to HIV], what I went through, they were always there. (Sprague et al. 2019, 12)

Metamorphosis holds us in its grip. Through grappling with the events that unfurl over the story's course, students can debate the role of empathy, as the text prompts perspective-taking on the nature of our own values and professional ethics in a given situation. For example, via Grete's character, Kafka succeeds in breaking open the complex ethics of caregiving, while rendering the burden of care and the need for empathy universally relevant (Gordon, Benner, and Noddings 1996). Indeed, Grete begins as a loving sister, energetically electing the caretaking of her brother. As reflects reality, caregiving becomes labor-intensive and thankless, resulting in Grete's eventual detachment from her patient. Caregiver fatigue and burnout, as well as the need for 'sustainable empathy' for patients has remained urgent for frontline health professionals, globally, who are treating patients with COVID-19—many without sufficient personal protective equipment, resulting in avoidable infections and deaths (see Zaki 2020; Ranney, Griffeth, and Jha 2020). When a character and text can elicit such vicariousness in the reader, it forces reflection, as Wear and Nixon write: "while these fictional mirrors must tilt outward to reflect features external to the reader, they must eventually rotate back to the reader herself" (1991, 57). Nussbaum, too, states that it is in exactly this way that literature extends our life and moral experience, allowing us to fully "reflect and feel...what might otherwise be too distant for feeling" ("The Partially Examined Life" 2016, 1). She observes that this way of reading literature tests "our aspirations to live a good life through events outside of our control.' And, thus, literature 'becomes a way of moral learning, a way of training ourselves to recognize the important features in a moral situation'" (1; see also Jones 1999). Such training is of high relevance for medical health students who will serve on the frontlines of both longstanding and emerging health threats.

Conclusion

Kafka's *Metamorphosis* can serve as a medium for exploring HIV stigma as a social-medical problem that threatens 'what matters most' (Yang et al. 2007). The text facilitates exploration of HIV stigma as a social process, debates over empathic responses to patients who experience stigma (and intersecting stigmas) among students of the health professions, and social determinants that influence their patients' opportunities to be healthy. Utilizing *Metamorphosis* on its own would be insufficient to serve as an anti-stigma intervention targeting HIV stigma at the structural level. However, the novella could be paired with other methods, such as those identified earlier, and/or materials, to establish more durable responses in clinical settings. Indeed, employing Kafka has transformative possibilities. First, a pedagogical approach using *Metamorphosis*, rather than conventional academic journals, to produce a deeper understanding of the social basis of ill health and SDH that undergird stigma, is one predicated on valuing knowledge from the humanities to inform medical knowledge by emphasizing the sociological-relational aspects of stigma. This aligns with recommendations to integrate STEMM, arts and humanities in medical education. Second, Kafka has established an opening for students to enter into reflection and dialogue about stigma as embedded in social structures—clinical, family and community settings—its complex mechanisms and inner-workings, in ways that are multi-disciplinary

and responsive to increasing health inequities for populations of color, sexual, gender minorities and other excluded groups. Here, literature enables readers to explore and discuss how the social and clinical worlds are intimately inter-connected, thus allowing students to reflect on moral, ethical concerns. This includes their professional identity and role within such structures: to perpetuate or change them. In this regard, Kafka offers an illustration of the very power of the medical health humanities to continue its social mission: to unfold such revelations in order for medical students, health professionals and researchers to fully grasp how sociological factors could enable, rather than disable, wellbeing—to ensure greater justice and equity in health and health care, particularly but not only, for people living with HIV (Vanderbilt University 2020; Berry, Jones and Lamb 2017).

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Endnote

¹ In response to the limits of empathy, recent research has placed attention on when, how much and which components of empathy allow humans to advance toward important goals. This includes improved wellbeing and relationship satisfaction, and preventing negative outcomes associated with empathy, such as health provider burnout, vicarious trauma, and the in-group bias that undergirds racism and social exclusion. By implication, while incorporating institutional structures and practices to reduce stress and burnout are recommended, scientists emphasize that determining which emotional regulation strategies (e.g., meditation) predict precise outcomes offers an exciting direction for future research (see Weisz and Cikara 2020).

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