

Article Title: Cultivating the dispositions to connect: an exploration of therapeutic empathy

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Abstract

Empathy is a broad concept that involves the various ways in which we come to know and make connections with one another. As medical practice becomes progressively orientated towards a model of engaged partnership, empathy is increasingly important in healthcare. This is often conceived more specifically through the concept of therapeutic empathy, which has two aspects: interpersonal understanding and caring action. The question of how we make connections with one another was also central to the work of the novelist E.M. Forster. In this article we analyse Forster's interpretation of connection – particularly in the novel *Howards End* – in order to explore and advance current debates on therapeutic empathy. We argue that Forster conceived of connection as a socially embedded act, reminding us that we need to consider how social structures, cultural norms, and institutional constraints serve to affect interpersonal connections. From this, we develop a dispositional account of therapeutic empathy in which connection is conceived as neither an instinctive occurrence nor a process of representational inference, but a dynamic process of embodied, embedded and actively engaged inquiry. Our account also suggests that therapeutic empathy is not merely an untrainable reflex but something that can be cultivated. We thus promote two key ideas. First, that empathy should be considered as much a social as an individual phenomenon. And second, that empathy training can and should be given to clinicians.

1. Introduction

In his novel *Howards End*, E.M. Forster explored how three families – the Wilcoxes, Schlegels and Basts – developed relationships in early 20th century England. The thesis of this exploration is made manifest in the novel’s famous epigraph: “Only connect...”.¹ Such a simple imperative drove much of Forster’s work and although its exact meaning is debated it has both individual and social aspects.² That the epigraph ends with an ellipsis and is derived from a fictional world further implies ambiguity, creativity and possibility in how we make connections with one another. Forster’s focus on connection has influenced many other writers and artists, perhaps most explicitly Zadie Smith in her 2005 novel *On Beauty*.³ Beyond such artistic horizons, with the medical treatment model of detached concern being replaced with one of engaged partnership, how we make connections with one another has become an important question in healthcare. This is increasingly considered through the concept of *therapeutic empathy*.

Drawing on literary criticism, philosophy and cognitive science, in this article we first provide an outline of current debates on therapeutic empathy, before using an exegesis of Forster’s focus on connection – particularly in *Howards End* – to frame an exploration of how these debates might be overcome. In brief, we propose that Forster’s emphasis on the socio-cultural contingency of connection can be usefully developed into a dispositional account of therapeutic empathy. The consequences of such an account loop back to inform current conceptual debates on what empathy is and how it might be achieved.

2. Therapeutic empathy

Empathy is a broad concept with a complex history. The word from which it was translated – *Einfühlung* (‘feeling into’) – was coined as a technical aesthetic term by Robert Vischer in the late 19th century.⁴ The notion of experiencing an aesthetic object through

projecting one's inner subjectivity was extended, by Theodor Lipps, to encompass how we might similarly come to know another's mental state.⁵ Empathy has since been variously conceptualised in many fields, including philosophy, psychology, literature, medicine, and cognitive science.⁶ From a medical perspective, clinicians and researchers are generally interested in empathy for two reasons. First, the epistemological notion that empathy is a foundational concept in interpersonal understanding.⁷ And second, the ethical notion that being empathic can engender sensitivity and caring action towards patients.⁸

2.1. Interpersonal understanding

With respect to empathy as a foundational concept in interpersonal understanding, research has largely focussed on the debate in philosophy of mind between *theory-theory* and *simulation-theory*. Broadly speaking, theory-theorists suggest we use a basic domain-specific framework of conceptual knowledge to infer the mental states of others.⁹ Simulation theorists deny that our understanding of others is quite so theoretical, instead suggesting that we use a model of our own mind to model the mind of others.¹⁰ In response to the dominant theory and simulation theories, some philosophers have proposed a different conception of empathy grounded in the phenomenological tradition.¹¹ In this *phenomenological proposal* empathy is “a kind of act of perceiving... *sui generis*”.¹² In arguing that theory and simulation theories focus too narrowly on explaining and predicting the actions of others, emphasis moves to the first-person character of consciousness, in which empathy refers to “our general ability to access the life of the mind of others in their expressions, expressive behaviour and meaningful actions”.¹³

Contemporary research, therefore, provides three broad options for conceiving of interpersonal understanding: inferring (*theory-theory*); simulating (*simulation-theory*); and directly experiencing (*phenomenological proposal*).¹⁴ Given the related longstanding disputes in philosophy of mind it is not surprising to note that these three approaches have not been

reconciled. But as we hope to highlight in this article, how one conceives of interpersonal understanding has significant practical consequences.

2.2. Caring action

The ethical notion that being empathic can engender sensitivity and caring action towards patients is, unlike interpersonal understanding, not always accepted as a necessary feature of empathy in general. This is because understanding someone does not lead inexorably to caring action.¹⁵ However, in the clinical context caring action is often included in an account of empathy because a clinician's role is, by definition, oriented towards caring for patients.¹⁶ The explicit inclusion of caring action alongside interpersonal understanding has thus been used to distinguish *therapeutic* empathy from empathy in general.¹⁷

2.3. Achieving therapeutic empathy in the clinic

Conceptual debates regarding therapeutic empathy notwithstanding, there is increasing evidence that empathic clinicians make better clinical judgements and improve treatment outcomes.¹⁸ Effective diagnosis and treatment requires reasoning processes that are engaged with, not detached from, a patient's everyday experiences and concerns.¹⁹ Modern clinicians now largely understand the limitations of detached concern and the benefits of actively engaging with their patients' ideas, concerns and expectations; movements such as person-centred care²⁰, values-based practice²¹ and narrative medicine²² have contributed to this transition. However, for overworked and pressurised clinicians with restricted consultation times, building genuine connections with patients can, in practice, be difficult.²³ Recent research in UK primary care, for example, suggests that clinician workload is increasing in terms of both consultation rate and duration.²⁴ This potentially restricts clinicians to conducting mechanistic diagnostic processes, which limits opportunities for building interpersonal relationships.

Forster captured the synthesis of rationality and value that characterises much modern medical practice in another famous lyrical phrase from *Howards End*: “the building of the rainbow bridge that should connect the prose in us with the passion”.²⁵ His plan for such construction, as we have noted, was at first glance a simple one – “Only connect!”²⁶ – in which the act of connection itself is foregrounded. However, Forster also recognised how difficult making connections can be given the manifest barriers to interpersonal understanding. Our exegesis of Forster is focused on exploring the effects of these barriers through two broad categories: connecting across public and private spheres; and connecting across socio-cultural and socio-economic divides.

3. Connecting across public and private spheres

Forster is seen by many critics as a pivotal novelist. For one so grounded in the sensibilities of English comic fiction, by his last novel – *A Passage to India* – he had transitioned to the foothills of modernism.²⁷ The many competing readings of Forster – from crypto-colonialist to liberal innovator – suggest he was writing at and across boundaries, both in style and subject. Boundaries were certainly important for Forster insofar as he sought to break down, or at least reconcile, “seeming opposites: the seen and unseen, the prose and the passion, the beast and the monk, the joys of the flesh on one side and the inconceivable on the other, the transitory and the eternal”.²⁸ One boundary Forster particularly sought to break down was that between the *public* sphere of state and business affairs, and the *private* sphere of personal relationships.

This attempt is evident in how Margaret Schlegel’s views develop in *Howards End*. At the start of the novel, Margaret’s sister Helen returns from an averted engagement to one of the Wilcox sons, Paul, “in a state of collapse”.²⁹ Discussing the differences between the entrepreneurial Wilcoxes and the cultured Schlegels, Margaret and Helen end up privileging the private ‘inner’ life that so informs their identity.³⁰

‘I’ve often thought about it, Helen. It’s one of the most interesting things in the world. The truth is that there is a great outer life that you and I have never touched – a life in which telegrams and anger count. Personal relations, that we think supreme, are not supreme there. There love means marriage settlements, death, death duties. So far as I’m clear. But here my difficulty. This outer life, though obviously horrid, often seems the real one – there’s grit in it. It does breed character. Do personal relations lead to sloppiness in the end?’

‘Oh Meg, that’s what I felt, only not so clearly, when the Wilcoxes were so competent, and seemed to have their hands on all the ropes.’

‘Don’t you feel it now?’

‘I remember Paul at breakfast,’ said Helen quietly. ‘I shall never forget him. He had nothing to fall back upon. I know that personal relations are the real life, for ever and ever.’

‘Amen!’

Despite Margaret and Helen privileging the inner, contemplative “real life” over the “obviously horrid” outer public life, even at this stage Margaret notes that the public life cannot be completely disregarded; after all, “there’s grit in it”, suggesting doubt as to which life is in fact the ‘real’ one. The necessity of the public sphere is more explicitly acknowledged when Margaret notes later that she is,

‘tired of these rich people who pretend to be poor, and think it shows a nice mind to ignore the piles of money that keep their feet above the waves. I stand each year on six hundred pounds, and Helen upon the same, and Tibby will stand upon eight, and as fast as our pounds crumble away into the sea they are renewed’.³¹

The “horrid” public sphere, Margaret realises, cannot be divorced from the contemplative private one because they are reliant on each other.

The central narrative in *Howards End* is the death of Mrs Wilcox (with whom Margaret had recently become friends) and Margaret’s subsequent improbable engagement to the widowed Wilcox patriarch, Henry. This partnering forces Margaret to further reconsider

her original stance and bring even closer together the public and private spheres she previously sought to separate.

The business man who assumes that his life is everything, and the mystic who asserts that it is nothing, fail, on this side and on that, to hit the truth. ‘Yes, I see dear; it’s about half-way between,’ Aunt Juley had hazarded in earlier years. No; truth, being alive, was not half-way between anything. It was only to be found by continuous excursions into either realm.³²

Extending Margaret’s position into healthcare, we can note that the medical consultation is, on the one hand, an encounter occurring in the public sphere; an institutional encounter between patient and (often state-sponsored) clinician in which the latter is the gatekeeper of essential services the former may require. But on the other, a clinical encounter can be incredibly personal, involving matters of life, death, trust, shared history and intimacy. To be empathic in the clinic, therefore, the transactional encounter associated with the public sphere must be transformed into interpersonal connections and forms of communion associated with the private sphere.

However, as Forster notes, such transformation is not a one-way street: “truth, being alive” requires “continuous excursion into either realm”. This is especially relevant in the clinic. The clinician also operates within the public sphere of the modern healthcare system; thus, it is not enough to merely reject the modern transactional encounter completely. To do so would be to not only reject the manifest advances of modern medicine, but also reject the necessary management of mundane and everyday institutional obstacles to good patient care. Obstacles that disproportionately impact certain marginalised groups. In achieving *therapeutic* empathy, therefore, the clinician is presented with the difficult task of not rejecting the transactional, but making it (partially) personal. Before conceiving in more detail how this difficult task might be achieved, we turn to the second barrier to connection foregrounded by Forster.

4. Connecting across socio-cultural and socio-economic divides

Margaret and Henry's engagement is endangered by connections with the third family of note in *Howards End*, the Basts. Prior to the engagement, Helen and Margaret initially try to help the Basts – Leonard and Jackie, a working-class couple – in part through advice they elicit from Henry. However, this proves unhelpful, leaving the Basts destitute. Through a series of events, which reach back past the union of Margaret and Henry to an affair between Henry and Jackie, the encounters between all three families lead to tragedy. Through the development of this narrative, Margaret explicitly acknowledges the necessity of extending interpersonal connection into the public sphere, insofar as it “[enlarges] the space in which you may be strong”.³³ Criticising Henry's poor judge of character and his ability to cast friends off “cheerily into oblivion”, Margaret now “never forgot anyone for whom she had once cared; she connected, [even] though the connexion might be bitter”.³⁴

By the close of *Howards End*, “Henry's fortress gave way”³⁵ and the connection Margaret strived for with the person she previously thought so “criminally muddled”³⁶ is, in part, achieved. However, as critics have noted, although Margaret and Henry have “learnt to understand one another and to forgive”³⁷, the same cannot be said for the connection between the Schlegels and Basts.³⁸ Having pitied and romanticised Leonard, Helen spends a night with him, which results in a child. Although Forster partly resolves this development through Henry's redemption and eventual acceptance and support of Helen, it is clear which family (and which class) gets the raw deal in the end. The central tragedy in the novel – the manslaughter of Leonard Bast by Charles, Henry's other son – highlights the difficulties and costs of failing to connect. As with Forster's other novels, *Howards End* reflects his central technique of “a revelation of the muddle experienced by people coerced by social convention and alienated from life and 'truth' of the body”.³⁹ Frank Kermode, in his 2007 Clark Lectures, suggests (citing Jonathan Rose) that Forster just fails with the character of Leonard

by underestimating the cultural advances of the British working class in the early twentieth century, thus producing an unfair caricature.⁴⁰ Whether one accepts this thesis or not, we can certainly take from Forster the uncomfortable truth that connecting across socio-cultural and socio-economic divides is more difficult than we might like to admit, even in the clinic.

This difficulty is captured in Forster's much quoted (and criticised⁴¹) end to *A Passage to India*. Following distressing events since resolved, the English Fielding asks the Indian Aziz "Why can't we be friends now?... It's what I want. It's what you want". Forster, instead of narrative closure, gives a lyrical response emphasising the barriers to the possibility of their friendship.⁴²

But the horses didn't want it – they swerved apart; the earth didn't want it, sending up rocks through which riders must pass single-file; the temples, the tank, the jail, the palace, the birds, the carrion, the Guest House, that came into view as they issued from the gap and saw Mau beneath: they didn't want it, they said in their hundred voices, 'No, not yet' and the sky said, 'No, not there.'

One interpretation of this ending suggests that Forster, by invoking natural or even metaphysical constraints, is advocating a kind of social conservatism. But this does seem at odds with Forster's approach to life more generally. Through his roles as a public intellectual and broadcaster he explicitly sought to avoid a "calcification" of "rigid attitudes... first through natural inclination and then, later, by way of a willed enthusiasm, an openness to everything".⁴³ With respect to achieving therapeutic empathy, therefore, a more useful interpretation of the ending to *A Passage to India* might be that, as with the Schlegels, Fielding's best intentions are not enough, providing a warning of the risks of voluntarism and overly liberal attitudes. Social change is required to facilitate or cultivate connections. While social barriers are entrenched in social structures, connection cannot be established solely by

an individual act of will (voluntarism); rather, such acts need facilitating and supporting by a shift in wider social structures (laws, attitudes and categories).

Although *A Passage to India* more obviously foregrounds cultural differences and is Forster's most famous novel, the critic Lionel Trilling suggests that *Howards End* is Forster's masterpiece. This is partly because it most develops Forster's central theme of connecting the prose and the passion into "a work of full responsibility" insofar as "it shows how almost hopelessly difficult it is to make this connection".⁴⁴ In Forster's earlier novels – *Where Angels Fear to Tread*, *The Longest Journey* and *A Room With a View* – we realise that connection can be a positive, passionate, and creative act. But most explicitly in *Howards End* we appreciate how much this is tested; how much work is required to achieve it across socio-cultural and socio-economic divides. To even attempt connection, Forster suggests, we must acknowledge this difficulty and take "full responsibility" for it. Furthermore, such full responsibility cannot merely be conceived at the individual level, achieved through personal change alone. In making an Aristotelian point against liberal moral epistemology, Forster reminds us that we need to consider how social structures, cultural norms, and institutional constraints serve to affect interpersonal connections. Put in Aristotelian terms: if we are to provide a social environment in which individuals connect, we need to think about the structure of the Polis and the training in the virtues, such that the former supports the cultivation and exercise of the latter. If we do not, we risk making the same mistakes the Schlegels do with the Basts.

5. A dispositional account of therapeutic empathy

In exploring Forster's focus on connection, we highlight two factors that can influence how we conceive of and achieve connection and thus therapeutic empathy: first, the interrelation of the public and private spheres; and second, the influence social, cultural and economic factors have on our ability to make meaningful connections with one another. We

suggest that the medical consultation is, paradigmatically, a hybrid of both public and private spheres, insofar as clinicians must connect interpersonally with patients whilst exploiting the manifest advantages of modern medicine. This suggests that to achieve therapeutic empathy, clinicians require contextual modes of practice that combine the transactional rationality of modernity with interpersonally created values, or virtues. Furthermore, given connection is so contingent on socio-cultural and socio-economic factors in the first place, such modes of practice must be considered at both interpersonal and social levels. Developing this analysis, we propose a dispositional account of therapeutic empathy in which connection is conceived as neither an instinctive occurrence nor a process of representational inference, but a dynamic process of embodied, embedded and actively engaged inquiry.⁴⁵

5.1. Cultivating the dispositions to connect

The idea that connection is not merely an instinctive occurrence is captured by another theme that pervades Forster's work: the *inadequate* or *undeveloped heart* he initially gives many of his characters.⁴⁶ As Zadie Smith notes, "we can hear in [Forster's undeveloped heart] an antithetical echo of Aristotle's 'educated heart'"⁴⁷ which must be developed and cultivated if a character is to succeed. Smith explicitly foregrounds this Aristotelian interpretation of Forster, noting that "training and refinement of feeling plays an essential role in our moral understanding" and "it is Forster who shows us how hard it is to will oneself into a meaningful relationship with the world".⁴⁸

We need not stick with Aristotle here. Training and refinement in dispositions can be explored via a number of philosophical schools, which share Aristotle's monism and commitment to cultivating moral dispositions (virtues). One could, for example, develop an account building on the work of ecological psychologists who have developed James Gibson's account and proposed a socialised account of affordances. Another, perhaps more fruitful, way to present this Aristotelian interpretation of connection (and thus empathy) is

through the language of a sophisticated modernist Aristotelian, the pragmatist philosopher John Dewey. For Dewey, as with Forster, although we cannot merely will ourselves towards making connections, we can consciously cultivate the *dispositions* to be able to make them in the first place. This suggests that therapeutic empathy can be partly trained and developed; clinicians can advance towards an “educated heart” even while accepting such advancement is an unending task. Dewey conceived of this process as one of developing and maintaining flexible habits, or dispositions to act.

For Dewey, good habits are not eternal and we must, depending on the situation, be capable of replacing a failing habit with a more successful one. It is, therefore, our power to develop multiple, flexible habits that stands us in good stead, whereby the “increased power of forming habits means increased susceptibility, sensitiveness, [and] responsiveness”.⁴⁹ Such dispositions to act are thus, for Dewey as Aristotle as Forster, not merely accidental developments but explicit cultivations. Furthermore, Dewey thought that to develop these flexible habits we need secondary ‘meta’ habits that allow us to actively reflect on (and if necessary adapt) our primary ones.⁵⁰ The Deweyan notion of actively reflecting on our primary habits characterises a Forsterian approach to connection, insofar as it is grounded, as Forster’s fiction is, explicitly in the idea that we can improve our approach to life through conscious development and training: many Forsterian protagonists – such as Margaret Schlegel, or Lucy Honeychurch in *A Room With a View* – develop towards making genuine connections by opening up to life, learning, and allowing their preconceptions to be challenged.

An important feature of Dewey’s dispositional account is the centrality and continuity of practical judgements. For Dewey, inquiry of any kind – be it moral or non-moral – involves transforming an indeterminate situation into a determinate one. This is achieved by making judgements about “the practical adequacy of a course of action to perform a specific

function”.⁵¹ Therefore, a moral judgement is not a different kind of judgement. All judgements involve the exercise of practical reasoning (*phronesis*) in which an indeterminate situation is made (locally) determinate. And because situations only become problematic when they frustrate our habitual actions, we need to have developed multiple flexible habits which allow us to respond reflexively to such problematic situations. Such an account has particular consequences for achieving therapeutic empathy. Within such a framework – whereby both moral and non-moral judgements are continuous (insofar as they are both modes of practical reasoning) – the difficult clinical task of balancing the transactional rationality of modernity with interpersonally created values dissolves. Both aspects require the exercise of practical reasoning in resolving problematic situations. Both aspects can be supported by the development of multiple flexible habits (dispositions to act).

5.2. Socio-culturally shaped dispositions

As we have already noted, a central theme of *Howards End* is the influence social, cultural and economic factors have on our ability to connect. That influence often enables connection within boundaries but constrains attempts to connect across them. As Forster demonstrated, by ignoring these influences the Schlegels – even with the best liberal intentions – ultimately ruined the Basts. The importance of such factors is also reflected in Dewey, who conceived of habits as not merely ‘in the head’ but embedded in and informed by the interactional social environment. Dewey conceived of this most explicitly through his concept of the *situation*, defined as an “enviroming experienced world”⁵² which includes the coupled organism-environment “always found together in a dynamical transactional relation”.⁵³ Within our Deweyan framework we support the development of therapeutic empathy through the cultivation of multiple flexible habits to connect with others. But, if we take Forster and Dewey seriously, we must also acknowledge that the cultivation of such

habits is inseparable from the social environments in which they are cultivated. Habits are not just dispositions to act, but socio-culturally cultivated, shaped and enabled ones.

Personal habits of action cannot be separated from the environment in which they are situated because that environment is also cultural. Our environment both influences our habits and is in turn reconfigured by the effects of our changing habits of action themselves. Empathy is as much a social as an interpersonal concept. To achieve therapeutic empathy, therefore, it is not enough to merely focus on interpersonal actions in the clinical encounter. We must also attempt to change our structural environment and the social practices within it.

6. Infer, simulate, or experience?

Grounded in an Aristotelian exegesis of Forster's focus on connection, we developed a dispositional account in which therapeutic empathy is conceived as a process comprised of dynamically related interpersonal actions and social practices. Armed with this account, we now return to the conceptual debates on therapeutic empathy we previously outlined. Specifically, the debate on whether interpersonal understanding is achieved through inference, simulation, or experience.

In theory-theory or simulation-theory, content is brought to bear by the mind. On such cognitivist accounts, meaning is inferred or simulated rather than read-off, experienced, or seen in the world. However, in talking of empathy in terms of cultivating dispositions, we are talking about attuning people to be responsive to the humanity of those they encounter. Through our modernist Aristotelian interpretation this occurs in an already socialised environment, therefore this,

reverses the notion that the experiencing of others occurs on the basis of an already fully developed individual mind, as assumed both by the formulation of a more or less naïve theory of other people's minds, and by the attribution to other people of mental states similar to those experienced in first person via embodied simulation.⁵⁴

In other words, it is difficult (perhaps even impossible) to give an account of how inferring or simulating interpersonal understanding is connected to or about the (life)world and others we encounter in it. The flexible habits so central to our Deweyan account are ecological, autopoietic structures embedded in the environment, not just in one's head.⁵⁵ The propositionally structured representations so central to theory-theory and simulation-theory seem ill-suited to account for this. We argue it is more accurate to suggest that therapeutic empathy is achieved through experience as per the phenomenological proposal.

Our account in part accords with a recent article by Marshall and Hooker, who promote an affective account of empathy by extracting a process-oriented modal-Spinozism from the work of Gilles Deleuze and Felix Guattari.⁵⁶ Marshall and Hooker's account broadly accords with our dispositional framework, insofar as a Deweyan account of multiple flexible habits echoes the Spinozist call to enhance our capacities to affect and be affected.⁵⁷ Our account can also be usefully compared with a recent philosophical view on defining therapeutic empathy, proposed on behalf of the Oxford Empathy Programme. In taking a broadly phenomenological view of therapeutic empathy, Bizzari et al. propose that "the clinician must strive to achieve two distinct, but interwoven, aims: ... *contemplate and feel* other's emotion... [and] transform it into an *empathic attitude*". This, they suggest, means that although the act of empathy itself is intuitive, "*therapeutic empathy as an attitude* (phase two) can be taught".⁵⁸ We echo the importance of training and development in developing the ability to be empathic, but suggest the phrasing of their definition is misleading, insofar as an "empathic attitude" (a disposition to be empathic) precedes not follows the empathic act (what Bizzari et al. term "empathic grasping"⁵⁹).

The history of debate in cognitive science and philosophy of mind suggests that non-representational, enactivist, ecological or ethnomethodological accounts of interpersonal understanding, such as we are proposing, are increasingly influential but still peripheral. Our

account may not change that perspective. Nevertheless, even if one remains unmoved by our account of exactly *how* therapeutic empathy is achieved, we may still – in a therapeutic sense – defuse one of the central problems regarding therapeutic empathy. Namely, by providing an account of how empathy is not merely an untrainable reflex we argue it can be cultivated. This seems like a worthwhile practical consequence of our account, philosophical debate notwithstanding.

7. Conclusion

There is increasing evidence that therapeutic empathy improves clinical outcomes but there are significant challenges to achieving it. In this article we explore therapeutic empathy through interpretations of connection in the work of the novelist E.M. Forster. We propose that the challenges to achieving therapeutic empathy can be partly mitigated through Forster's conception of connection as a socially embedded act, which we cash out in an ecological, dispositional account of empathy. This suggests that therapeutic empathy is not achieved through inference or simulation, but through a form of active experience. Philosophical debate notwithstanding, we argue that howsoever one conceives of therapeutic empathy, it is something that clinicians can cultivate through education and training.

Patient and public involvement (PPI) statement

There were no funds or time allocated for PPI so we were unable to involve patients.

Notes

- ¹ E. M. Forster, *Howards End* (Great Britain: Penguin Books, 1910/1960), 3.
- ² M. J. Miller, "Sympathetic Constellations: Toward a Modernist Sympathy" (UC Berkeley, 2012).
- ³ Zadie Smith, *On Beauty* (London: Penguin Books, 2005).
- ⁴ Amy Coplan and Peter Goldie, "Introduction," in *Empathy: Philosophical and Psychological Perspectives*, ed. Amy Coplan and Peter Goldie (Oxford: Oxford University Press, 2011).
- ⁵ Valeria Bizzari et al., "Defining Therapeutic Empathy: The Philosopher's View," *Journal of the Royal Society of Medicine* 112, no. 3 (2019).
- ⁶ See Coplan and Goldie, "Introduction." for a concise history of empathy in philosophy and psychology.
- ⁷ Peter Goldie, "How We Think of Others' Emotions," *Mind & Language* 14, no. 4 (1999); Dan Zahavi and Soren Overgard, "Empathy without Isomorphism: A Phenomenological Account," in *Empathy: From Bench to Bedside*, ed. Jean Decety (London: The MIT Press, 2012).
- ⁸ Jodi Halpern, "Clinical Empathy in Medical Care," *ibid.*; Stewart W Mercer and William J Reynolds, "Empathy and Quality of Care," *British Journal of General Practice* 52, no. Suppl (2002).
- ⁹ Coplan and Goldie, "Introduction."
- ¹⁰ Alvin I. Goldman, *Simulating Minds : The Philosophy, Psychology, and Neuroscience of Mindreading*, Philosophy of Mind Series (New York: Oxford University Press, 2006); Karsten R. Stueber, *Rediscovering Empathy: Agency, Folk Psychology, and the Human Sciences* (Cambridge MIT Press, 2006).
- ¹¹ Matthew Ratcliffe, "Phenomenology as a Form of Empathy," *Inquiry* 55, no. 5 (2012); Fredrik Svenaeus, "Edith Stein's Phenomenology of Sensual and Emotional Empathy," *Phenomenology and the Cognitive Sciences* 17, no. 4 (2018); Dan Zahavi, "Empathy and Direct Social Perception: A Phenomenological Proposal," *Review of Philosophy and Psychology* 2, no. 3 (2011).
- ¹² E. Stein, *On the Problem of Empathy* (Washington D.C.: ICS Publications, 1917/1989), 11.
- ¹³ Dan Zahavi, "Empathy and Other-Directed Intentionality," *Topoi* 33, no. 1 (2014): 138.
- ¹⁴ We stick here with this trio. Of course, one could proceed from a turn to phenomenology to invoke one of the accounts of responsiveness to loci of significance and object-involving abilities that inherit phenomenology, such as (socialised) ecological psychology, 4E cognition and ethnomethodology. For our purposes, here we will focus solely on phenomenology, rather than its various developments.
- ¹⁵ Max Scheler, *The Nature of Sympathy* (London: Routledge & Kegan Paul, 1954).
- ¹⁶ Mercer and Reynolds, "Empathy and Quality of Care."
- ¹⁷ J. Howick, V. Bizzari, and H. Dambha-Miller, "Therapeutic Empathy: What It Is and What It Isn't," *Journal of the Royal Society of Medicine* 111, no. 7 (2018); Doug Hardman and Jeremy Howick, "The Friendly Relationship between Therapeutic Empathy and Person-Centred Care " *European Journal for Person Centred Healthcare* 7, no. 2 (2019).

¹⁸ Frans Derksen, Jozien Bensing, and Antoine Lagro-Janssen, "Effectiveness of Empathy in General Practice: A Systematic Review," *The British Journal Of General Practice: The Journal Of The Royal College Of General Practitioners* 63, no. 606 (2013); Jeremy Howick et al., "Effects of Empathic and Positive Communication in Healthcare Consultations: A Systematic Review and Meta-Analysis," *Journal of the Royal Society of Medicine* 111, no. 7 (2018); Trisha Greenhalgh, Jeremy Howick, and Neal Maskrey, "Evidence Based Medicine: A Movement in Crisis?," *BMJ* 348 (2014).

¹⁹ Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (USA: Oxford University Press, 2006).

²⁰ Inger Ekman et al., "Person-Centered Care — Ready for Prime Time," *European Journal of Cardiovascular Nursing* 10, no. 4 (2011). For comment, see also: Michael Loughlin, "What Person-Centred Medicine Is and Isn't: Temptations for the 'Soul' of Pcm," *European Journal of Person-Centred Healthcare* 2, no. 1 (2014).

²¹ K. W. M. Fulford, "Values-Based Practice: A New Partner to Evidence-Based Practice and a First for Psychiatry?," *Mens sana monographs* 6, no. 1 (2008). See also the collection Michael Loughlin, ed. *Debates in Values-Based Practice: Arguments for and Against* (Cambridge: Cambridge University Press, 2014).

²² Rita Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," *JAMA* 286, no. 15 (2001).

²³ Jodi Halpern, "What Is Clinical Empathy?," *Journal of General Internal Medicine* 18, no. 8 (2003).

²⁴ F. D. Richard Hobbs et al., "Clinical Workload in Uk Primary Care: A Retrospective Analysis of 100 Million Consultations in England, 2007–14," *The Lancet* 387, no. 10035 (2016).

²⁵ Forster, *Howards End*, 174.

²⁶ *Ibid.*

²⁷ Elizabeth Langland, "Forster and the Novel," in *The Cambridge Companion to E.M. Forster*, ed. David Bradshaw (Cambridge: Cambridge University Press, 2007). Forster posthumously published a novel, *Maurice*, in 1971; however, this was written before *A Passage to India* and thus, in developmental terms, *A Passage to India* is considered to be Forster's last novel.

²⁸ *Ibid.*, 98.

²⁹ Forster, *Howards End*, 23.

³⁰ *Ibid.*, 27.

³¹ *Ibid.*, 59.

³² *Ibid.*, 182.

³³ *Ibid.*, 175.

³⁴ *Ibid.*, 194.

³⁵ *Ibid.*, 313.

³⁶ *Ibid.*, 287.

³⁷ *Ibid.*, 315.

³⁸ David Bradshaw, "Howards End," in *The Cambridge Companion to E.M. Forster*, ed. David Bradshaw (Cambridge: Cambridge University Press, 2007).

³⁹ Langland, "Forster and the Novel," 95.

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- ⁴⁰ Frank Kermode, *Concerning E.M. Forster* (London: Phoenix, 2010).
- ⁴¹ See, for example, Edward Said, *Orientalism* (London: Penguin Books, 1978/2003), 244. Said feels Forster's "compact definition" leads to a sense of "pathetic distance" separating the West from the Orient and reaffirming the allowance of connection only on Western ideological terms. There is clear value in this critique in unmasking potential latent prejudice in Forster's work. But it does seem a bit uncharitable, particularly when situated in Forster's longstanding faith in life and wider focus on the difficulties of connecting across myriad intra- and inter-cultural boundaries.
- ⁴² E. M. Forster, *A Passage to India* (London: Penguin Books, 1924/1979), 288.
- ⁴³ Zadie Smith, "E.M. Forster, Middle Manager," in *Changing My Mind: Occasional Essays*, ed. Zadie Smith (London: Penguin Books, 2009), 24.
- ⁴⁴ Lionel Trilling, *E.M. Forster*, 2nd ed. (London: The Hogarth Press, 1967), 102.
- ⁴⁵ Following our suggestion in fn. 14, we might conceive of this in terms of social affordances e.g. Alan Costall, "Socializing Affordances," *Theory & Psychology* 5, no. 4 (1995). Or in terms of the cultivation of ethno-methods, e.g. Harold Garfinkel, *Studies in Ethnomethodology* (USA: Polity Press, 1967/1984); *Ethnomethodology's Program: Working out Durkheim's Aphorism* (USA: Rowman & Littlefield Publishers, 2002).
- ⁴⁶ Zadie Smith, "Love, Actually," *The Guardian*, 1/11/2003 2003; Trilling, *E.M. Forster*.
- ⁴⁷ Smith, "Love, Actually."
- ⁴⁸ Ibid.
- ⁴⁹ John Dewey, *Experience and Nature* (USA: Dover Publications, 1925/2013), 281.
- ⁵⁰ *Human Nature and Conduct* (New York: Dover Publications, 1922/2002).
- ⁵¹ J. Welchman, "Dewey's Moral Philosophy," in *The Cambridge Companion to Dewey*, ed. M. Cochran (Cambridge: Cambridge University Press, 2010), 167.
- ⁵² John Dewey, "Common Sense and Scientific Inquiry," in *The Essential Dewey Volume 1: Pragmatism, Education, Democracy*, ed. L.A. Hickman and T.M. Alexander (USA: Indiana University Press, 1938/1998), 383-4.
- ⁵³ S. Gallagher, *Enactivist Interventions: Rethinking the Mind* (USA: Oxford University Press, 2017), 54.
- ⁵⁴ Roberta Dreon, "Framing Cognition: Dewey's Potential Contributions to Some Enactivist Issues," *Synthese* (2019): 9.
- ⁵⁵ Xabier E. Barandiaran and Ezequiel A. Di Paolo, "A Genealogical Map of the Concept of Habit," *Frontiers in Human Neuroscience* 8, no. 522 (2014).
- ⁵⁶ George Robert Ellison Marshall and Claire Hooker, "Empathy and Affect: What Can Empathied Bodies Do?," *Medical Humanities* 42, no. 2 (2016).
- ⁵⁷ Furthermore, the scholastic metaphysics that underpins the Deleuzian virtual-actual modal distinction Marshall and Hooker lean on in their article is prefigured in pragmatism; most explicitly in Charles Sanders Peirce who had a conception similar to Deleuze's actualisation of the virtual, made manifest in his categories of Firstness, Secondness, and Thirdness. The connection can in part be traced to Peirce and Deleuze's interest in the scholastic philosopher Duns Scotus.
- ⁵⁸ Bizzari et al., "Defining Therapeutic Empathy: The Philosopher's View," 93.
- ⁵⁹ Ibid.

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