Understanding empathy: Why phenomenology and hermeneutics can help medical education and practice

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Abstract

This article offers a critique and reformulation of the concept of empathy as it is currently used in the context of medicine and medical care. My argument is three pronged. First, that the instrumentalised notion of empathy that has been common within medicine erases the term's rich epistemological history as a special form of understanding, - even a vehicle of social inquiry, - and has instead substituted an account unsustainably structured according to the polarisations of modernity (subject/object, active/passive, knower/known, mind/body, doctor/patient). I suggest that understanding empathy by examining its origins within the phenomenological tradition, as a mode of intersubjective understanding, offers a different and profitable approach. Secondly, I argue that the appropriation of empathy in medicine means that, ironically, empathy can function as a technique of pastoral power, in which virtue, knowledge and authority *remain with the doctor* (Mayes, 2009). And thirdly, empathy is in danger of being resourced as a substitute for equity and funding within health systems. I conclude however with hope for the productive possibilities for empathy.

Keywords: Empathy, sympathy, phenomenology, understanding, medical humanities, patient experience

Introduction

Empathy is one of the key hallmarks of good doctoring. The extensive research that has been devoted to the topic has repeatedly confirmed that patients place a very high value on empathy in interactions with their doctors. Empathy is no mere desirable add-on to technically competent practice; instead, it is often crucial to therapeutic success (Halpern, 2003) (Pedersen, 2008, 2009). Patients who perceive their doctor as empathic have on average better outcomes across a range of technical measures, such as physiological function, compliance with treatment regimens, medication use, and so forth, than those who do no not (Hojat et al., 2011; Hojat et al., 2013; Hojat, Louis et al. 2011, 2013, Derksen, Bensing et al. 2013, Gleichgerrcht and Decety 2013). It is widely accepted that empathic practitioner-patient relationships can produce powerful, therapeutically positive, 'context' effects (Di Blasi et al., 2003). Empathy facilitates patient understanding of treatment options and participation in decision making, making it a key tool in patient-centred care (Halpern, 2001) (Halpern, 2014). Finally, all this research tends to show that empathy is good for doctors too, providing them with enhanced job satisfaction and better self-care (Larson et

al., 2005).

But if the importance of empathy to successful therapeutic practice is well established, so too is the worrisome lack of it amongst doctors (and to varying degrees, other health care workers also (Ward et al., 2012)). Study after study has demonstrated a decline in empathy among medical students and recent graduates (Pedersen, 2010), a decline that medical educators have been anxious to arrest by such methods as using art and literature to extend students' imaginative and emotional repertoires, attentiveness to patient narratives, and reflective journaling (Burks et al., 2012; Garden, 2007). While such strategies have doubtless produced many benefits to individual clinicians and their clients, educational palliatives alone do not prevent student empathy from dropping drastically around the third year of medical training and remaining far short of what is ideal (Hojat et al., 2009; Tavakol et al., 2012).

Moreover, despite its normative status as a good thing for a doctor to have, medical writers periodically express concerns about how real, and how beneficial, empathy actually is. Physician commentators tend to worry that empathy places unreasonable emotional demands on doctors, contributing to 'burnout'; and/or that compelling apparent insights into patient experience mostly turn out to be merely chimeric projections of the doctor's. The scholarly world has supplied well thought out theoretical bases for these practical concerns – these are set out in section 2, below. As other scholars have commented, empathy – at least in the world of medicine - is poorly defined and conceptually unclear. There continue to be disagreements about the degree to which a doctor can either 'know' or 'feel' (for) another, and whether, consequently, empathy is something doctors are actually either capable, or truly desirous, of (Macnaughton, 2009). Others argue that empathy is merely yet another concept that medicine has appropriated for its own instrumental purposes, with impacts that potentially disempower patients or (ironically) re-establish the epistemic authority of the doctor (Garden, 2007; Macnaughton, 2009; Pedersen, 2008).

This article extends these critiques of medical empathy. It is prompted by research from Macnaughton, Pedersen, Garden and others, all of whom question the ways in which medicine has conceived of and sought to utilize the concept. My contribution here is three pronged. First, that the instrumentalised notion of empathy that has been common within medicine erases the term's rich epistemological history as a special form of understanding, - even a vehicle of social inquiry, - and has instead substituted an account stranded on the polarisations of modernity (subject/object, active/passive, knower/known, mind/body, doctor/patient). Reflecting the degree to which medicine itself is still framed by these polarisations, in this account empathy is a key route by which to access the psychosocial aspects of illness. But empathy refuses to be 'enrolled' (Callon, 1986) as the bit of nice that was felt to be missing in medicine's resolutely reductive, narrowly technical epistemology. I suggest that instead, empathy functions as the 'return of the repressed' in medicine. It requires us to face up to the deep challenges that accrue to a social practice like medicine (Fitzpatrick et al., 2014), and makes visible why it happens, and why it matters, that biomedicine continues to reproduce distinctions between mind and body, knowledge and society, technical knowledge and 'medical humanities', instead of looking to the ways in which these are inseparable, integrative and dynamically interactive. It requires facing up to the relationship between qualitative and quantitative epistemologies: might we say, between ways of understanding and ways of knowing? Secondly, I argue that the appropriation of empathy in medicine functions mostly as a technique of pastoral power, in which knowledge and authority *remain with the doctor* (Mayes, 2009). And thirdly, empathy is in danger of being resourced as a substitute for equity and funding within health systems,

drawing attention away from the structural and systemic reproduction of inequality and of the way power operates in these systems, and discursively resituating care, compassion and virtue within the patient-doctor dyad and not within the communal context of health, illness, and healing. Viewed from this position, empathy becomes reduced to the emotions of which neo-liberal subjects are capable.

But despite this strong critique of medical empathy, I don't wish to jettison the concept. Au contraire, I argue that medicine may wish to be attentive to the rich, complex accounts of intersubjectivity and experience that are now being generated by scholars reconnecting with century-old debates about empathy in the traditions of phenomenology and hermeneutics. These direct us to much more powerful and challenging ways of approaching what empathy can be within medical epistemology and practice.

The research base for this article is a literature review that is not exhaustive (the literature on empathy numbers in the thousands of papers), but which has instead utilized theoretical sampling and snowballing techniques familiar to qualitative researchers and building on existing reviews and collections (Pedersen, 2009; 2010). From an initial large pool of papers generated by searching medline and pubmed over the past ten years, I accumulated literature via references in papers from the initial sample, and pursued related database searches as I developed themes and concepts. This is a philosophical and analytic approach, not an empirical synthesis; indeed, remarkably little of the empathy literature is empirical, while a lot implicitly or explicitly grapples with philosophical conundrums. As with accounts like Pedersen's, Macnaughton's, and Garden's, this one utilizes the philosophical and historical antecedents of contemporary debates on empathy - in this case, specifically, empathy's historical location in the origins and development of the phenomenological tradition - to provide new perspectives on the concept's use in medicine, and to a lesser degree, other fields where empathy is relevant, such as neuroscience, psychology and psychotherapy.

1. Empathy in medicine: conceptual confusions

For the contemporary medical student – let us term him or her a Standardised Medical Student or SMS - empathy is now mandatory. This student will be informed of the benefits and importance of empathy; s/he is even likely to be graded on her/his 'verbal expression of empathy', or measured for his/her 'level' of empathy, or something equivalent, at some point in his/her training. It may strike some of these students, as it strikes some philosophers and commentators, that there is a discomfiting gap between being *marked* or *measured* for, let alone compelled to, empathy, and the subtle, multivalent, unique and interpretive forms of relating people would claim they 'experience' in actual empathic interactions (Jamison, 2014).

If s/he receives any explicit teaching on the topic of empathy at all, we can make a reasonable guess that the SMS is likely to be taught something along the lines that: empathy involves attention to non verbal cues and to the emotional and psychosocial aspects of illness; that this empathic register of patient experience augments a doctor's understanding of or information about the patient; which in turn aids accurate diagnosis and increases patient self-efficacy and thus compliance with treatment regimens (Halpern, 2001). These are the sort of convincingly instrumental and pragmatic terms that form the general currency for persuading reluctant, exam-oriented, high fee paying SMSes to pay attention to anything not technical or examinable. A passionate medical educator may suggest something less reductive – perhaps that a truly good doctor can find in themselves a capacity for 'emotional resonance' (Halpern, 2001), though such phrases run the risk of

sounding romantic or lacking in rigour (which Halpern's own work in fact is not (see eg(Garden, 2007; Halpern, 2014)), but the contrast remains between academic terminology and the vocabulary of empathy experiences). Such an educator might suggest 'reflective practice' or narrative practice as the chief route to empathy (Derksen et al., 2013).

As a result the SMS has a fair chance of perceiving medical empathy as either epistemically weak or as another form of hoop-jumping enculturation. Epistemically, in medicine empathy is conceptualized metaphorically. For example, a quantitative instrument such as the Jefferson Empathy Scale (an often-cited measure developed specifically for application to doctors and medical students (Hojat, 2007), one among many quantitative instruments relevant to empathy (Pedersen, 2009)) measures a doctor's 'level' of empathy. A 'level' sounds like something real, especially if it is measurable: but what is a 'level' of empathy really? (I picture medical students with tiny Galenic vessel-like hearts that spill out empathy, like the gentle rain from heaven, upon their patients). Other scholars of medical empathy imagine it variously as skill or behavior, or capacity or trait, or possession or process, or signification or interaction – and one might hypothesize that a sophisticated qualitative inquiry into medical students' own ways of conceiving / experiencing empathy would find the concept constructed in different terms still (Tavakol et al., 2012). Lakoff and Johnson remind us that such representatives are not just window dressing, but often generate and normalize discourse that shapes practices of diagnosis, judgment, and remediation, not to mention neural research (Coplan et al., 2011) (Lakoff et al., 2003).

Underpinning these (already substantive) representational variations, there are long-running arguments within the academic literature on medical empathy, with varying authors claiming and counterclaiming that empathy is or is not primarily cognitive or primarily emotional; requires or confounds a stance of detachment; does or does not enable sharing of or access to another person's 'experiences' (Pedersen, 2008). But these arguments are founded on common (and problematic) assumptions, as we see in the next section.

2. Understanding empathy

In medicine, empathy is commonly represented in responsive terms: 'feeling another's pain', 'feeling *with* another' or, quoting Lipps (the term's first proponent and populariser, in the late nineteenth century), 'feeling *into* another' (Bruns et al., 2011; Derksen et al., 2013; Gelhaus, 2012). But empathy derives its status and value from something more than mere emotional responsiveness. Despite these common definitions in terms of feeling, what really matters is that such a feeling does something or creates something for the empathizer. It is *intentional* (as phenomenologists, but not writers on medical empathy, would say); it is 'about' something. Empathy is, or generates, a form of '*understanding*' the patient (for a useful summary of some shifts in how this has been conceptualized, see (Coplan et al., 2011) (Stueber, 2006). It is this understanding that makes empathy important in medical care and confers all the benefits of increased therapeutic discrimination and compliance. And patients are reportedly profoundly desirous of being 'understood' (Broyard, 1993). But what *is* this 'understanding'? Is it a form of knowledge? If so, of what kind, and with what implications (Gelhaus, 2012)? Is it knowledge limited to a particular domain: that of the patient's emotions and personhood, the qualities of their 'experience' – aka, the 'psychosocial'? The bits that are not the technicalities of their diagnosis or pathology? Or is it false knowledge, deception, the mere projection of one's self?

Although scholarship on medical empathy is usually not explicit on these points (not having posed the question in such terms), implicitly empathic 'understanding' is indeed treated as a

kind of knowing. And as a result, the question of what weight and role to give cognition and emotion respectively has bedeviled this scholarship from the beginning. For if feeling emotion is a central part of what empathy is about, then empathising doctors must confront the question of how to distil emotion into valid knowledge - 'understanding' – as well as how to avoid 'burnout' (emotional fatigue) in the process. It is an acute problem because in all these accounts emotion is normatively constructed as the opposite of rationality and objectivity, and as consequently posing a threat to the legitimacy of any resulting knowledge. Directly related to this problem is the question of how to understand the relations between the empathizing self and the object of empathy, the other person. Here scholars are divided as to whether or not empathy constitutes some form of direct access to the other's experience, as the common formula of 'feeling with' or 'feeling into' suggests (eg (Macnaughton, 2009)), or, alternatively, whether it might incorporate a capacity for assessing or analyzing that experience. Either could be considered as a valid form of 'understanding'; but what role the empathizing subject's imagination - something more than mimesis or simulation – might play in each case, is similarly a matter of concern and dispute.

One common strategy for coping with these thorny issues has been for scholars to insist on distinguishing between empathy and sympathy, words whose relation to one another might have been understood more in terms of context-of-use had the need for categorical distinctions been less urgent. The distinction – constructed in utterly contradictory ways from author to author - has been a vital resource for both arguments concerning epistemological legitimacy and those concerning appropriate self/other relations (while pity, compassion, sensitivity, concern, rapport and the rest of the family of empathy's synonyms have failed to come anywhere close to empathy's status and power – presumably they occupy the territory of mere affective response rather than being elevated to 'understanding').

Thus in some accounts, empathy is defined as detached and purely cognitive, with sympathy positioned as the repository of all physicians' emotion (eg(Hojat, 2007; Hojat et al., 2001)). In this version, 'understanding' the patient involves making an objective, distanced, assessment of them. Halpern (and Spiro and others), deliberately oppose such cognitive accounts, associating them with a problematic tradition of erasing emotion in Western doctoring. She counter-defines empathy as 'essentially an *affective* mode of understanding', whose crucial feature is that the empathizing doctor is moved by the patient's experiences (Halpern, 2003). Macnaugton, taking the next turn, and objecting to the claim that emotional resonance might constitute an epistemic sharing of the other's experience – also worried about the ease with which imaginative projections might appropriate that experience, and ethically disquieted by doctors claiming to 'understand' an experience whose constraints and consequences they do *not* have to share in – prefers, like Hojat, to categorise all emotional response to patients as 'sympathy', but unlike him, claims that this is all that is either possible or desirable for doctors, since true Buberian I-thou relations – empathy - are impossible within the constraints of the doctor-patient interaction (Macnaughton, 2009); see also (Slaby, 2014).

Thus while these approaches to empathy stand in apparent disagreement with one another, in fact they all are predicated on constructing empathy in ways that safeguard the objectivity of scientific medical knowledge and the epistemic neutrality of the doctor (Pedersen, 2008; Schertz, 2007), and all their disagreements arise from the difficulties in sustaining this illusory construction. In one of the strongest critiques of medical empathy produced recently, Pedersen argues that medical empathy accommodates to – I would say '*reproduces*' - the inadequate ideals of objectivity and instrumentalism that are dominant in

medical discourse, consequently marginalizing or denying the subjectivity of the empathizing doctor and the hermeneutic context in which medical interactions occur (Pedersen, 2008). This elision of subjectivity is, for example, foundational to research projects that test a doctor's 'empathic accuracy' (eg (Bylund et al., 2005)), or that encourage the psychotherapeutic merging with or matching the other's gestalt. Another chief strategy to discursively preserve objectivity and neutrality is to construct emotion as a form of contaminating bias and place it under firm cognitive control (Derksen et al., 2013; Gleichgerrcht et al., 2013).

Another way of putting this would be to say that medical empathy is a *discourse* constructed in ways that reproduce the discursive polarities of modernity (Latour, 1993): mind and body, cognition and emotion, objective and biased, subject and object, doctor and patient, the 'science' from the 'art' of medicine, active and passive, male and female, science and nature (the JES finds that female doctors are more likely to have higher empathy scores than males (Hojat et al., 2013)). In this view, the various versions of medical empathy discursively perform the 'work of purification', re-establishing these unstable polarities, even as they are destabilized by the interactions between people, discourses and things (like bodies and pathogens).
I emphasise: It is not that the increasing technicality of medicine, nor even its epistemic scientism, has driven medical students increasingly far away from empathic care, which is the most common way in which the problem is framed. Rather, the *framing of the problem itself* – exemplified in constructions of medical empathy, and in the role generally assigned to the 'medical humanities' in general – reproduces the construction of scientific medicine as separate from and opposite to affective care, and requires the SMS to take up one antithetical subject position or the other.

From this perspective, one of the most untenably 'modern' of approaches to medical empathy, turns out to be that of the JES, with its firm expulsion of emotion and its static ontology, and indeed, most quantitative instruments used to measure empathy can be similarly critiqued (Pedersen, 2009). Scholars in the humanities would be unsurprised: protest against reductive quantitative methodologies that collapse nuanced, contextual aspects of human life (such as subjectivity) into context-insensitive variables are routine – so much so that they rarely give any attention to the specific methods and claims under critique. And yet the JES seems to produce results with which many would concur, such as the correlation between gender and empathy, or the timing and existence of the drop in students' empathy levels, or the capacity of empathy to impact on physiology (Hojat et al., 2009). How is it possible that something conceptually flawed can produce results that seem to be 'true'? And if the JES 'works', that begs a further question: what exactly is it – level, trait, capacity, resonance, skill, attitude, stance – that the JES is *actually* measuring? Before I move on to historicise empathy, I want to expend a couple of paragraphs on an analysis of the JES. It's worth doing because this is a serious epistemological question not elsewhere addressed, not even in Pedersen's comprehensive and thoughtful analysis (Pedersen, 2009). And by corollary, there is more to be said about what different methodologies allow us to 'see' when we research empathy.

3. Knowing empathy: the Jefferson Empathy Scale and what empathy is

The JES has a very modest aim: in the absence of other measures specific to medical practice and education, it was a developed as a tool to further empirical investigation of empathy and its implications for patient care (Hojat, 2007; Hojat et al., 2001). It was not intended to elucidate the philosophical dimensions of empathy, nor to explore the characteristics or

processes of student or practitioner (or patient) empathies, nor even to identify all the aspects of the variance of its own components. It was intended merely to provide a *sufficient*, *approximate* indicator of 'empathy' so we could learn a bit about why empathy might have impacts. Empathy could otherwise be allowed to remain a black box in practice.

And indeed, the JES achieves those aims. Pedersen's review rightly critiqued the JES because most of the actual items on the scale ask respondents about their *belief in* the importance of empathy, not about things that might be features of (or indicate features of) empathy itself (Pedersen, 2009). But the question is, does this matter? It won't matter if it turns out that measuring someone's belief in the importance of empathy actually also measures 'empathy' itself. And the methodology used indicates that that is precisely what happens. It identifies a list of questions where the responses co-vary across the sample of medical students on which it was tested, with a sufficiently strong indication that they co-vary *because* they all measure an underlying factor that we can call 'empathy'. This factor accounts for 56% of the variance (Hojat et al., 2001). The other 44% of the variance is left unaccounted for, and we cannot identify whether that is the result of so-far undiscovered aspects of empathy, or about belief in empathy but not 'empathy' itself, or from other factors unrelated to empathy. Although this is a large percentage to have unaccounted for, it is regarded as unimportant, because the strength of the covariance is considered both a sufficient and plausible indicator of empathy in accordance with the norms of psychometric instruments.

And the results the instrument has delivered tend to confirm this. Hojat has used the tool successfully: it has allowed him to 'see' that changes in student empathy occur predictably and reliably across the student population at a particular stage in their medical education (Hojat et al., 2009); that empathy varies equally predictably with other demographic factors, such as specialization within medicine; and – very importantly and convincingly for an often skeptical quantitative clinical audience – that physician empathy is correlated with improved physiological outcomes and increased physical benefits in patients (Hojat et al., 2011).

So the JES may indeed be regarded as delivering *something* epistemologically valid (which we can term a level or a trait or a magic wand, as we choose). But, as noted, not only will the JES not delineate anything about what empathy is or how it 'works', it tells us only something fairly general and crude about those that 'have' it. It is dubious that the JES could distinguish between empathy, sympathy, pity, compassion, patient-centredness, narrative medicine, active listening, mindful or any of the other forms of highly relational, engaged, emotionally present, forms of clinical care. That problem *does* stem from the JES' impoverished philosophical foundations. Not only is the JES based on a definition of empathy as wholly cognitive, but this is in turn vested in a view of cognitive systems as *higher order* and separate from the 'primitive', biasing, 'arousal' systems that produce emotion:

'Understanding is often based on tangibility and objectivity, whereas feeling is a product of subjectivity and can thus be subject to prejudice… a higher mental processing is involved when attempting to understand a person's concerns, whereas a primitive mental process is involved in feeling another person's emotions.' (Hojat, 2007)

This hierarchical epistemological framework is troubling not only because of the vast quantity of physiological, neurological, social and cultural research that now show how interconnected cognition and emotion actually are, but also because we know have extensive understanding of how greatly this modernist episteme rests in and is productive of forms of social and cultural inequality, with the quantified, implicitly masculine definition of

empathy as objective, privileged and disembodied knowledge defined in opposition to the primitive, emotional, biased 'understanding' of the (embodied, female, natural) known Other (Haraway, 1991; Harding, 1991). Viewed from this perspective, the JES tells us very little that is meaningful about empathy but an awful lot about how the medical profession continues to create and perpetuate cultural mythologies about the objectivity, epistemological privilege and emotionally invulnerable and inviolate physician.

However in addition to providing some useful basic knowledge about where empathy might have real impacts in medicine, the JES also performed the really useful academic function of advancing debate about empathy itself. The new norm in medical empathy modelling is functionalist. Recently produced models of clinical empathy are multifaceted and incorporate cognitive, affective, behavioural, communicative / responsive and/or moral elements (Binmore, 2005; Derksen et al., 2013; Gelhaus, 2012; Gleichgerrcht et al., 2013); see also (Halpern, 2014). Pragmatically, many of these writers suggest that each functional aspect be utilized to the extent relevant for medical practice: what is important, indeed, is *competencies* (Derksen et al., 2013). Thorny philosophical questions have been put aside.

So these days the SMS is equipped with a construct that is Taylorised as an instrument of efficient ethical care, in which they control the extent of their affective and cognitive input: I term this normative version 'efficient empathy'. But efficient empathy, so apparently unobjectionable, integrated and multifaceted, still contains within it unresolved tensions.

4. Empathy, biopower and neo liberal medical practice

Empathy is supposed / anticipated to be a modality that supports the mutual interests of doctor and patient and that encourages attention and responsiveness to the patient's needs. But paradoxically it is also a feature of late modern neoliberal health care, produced by and productive of the power relations, forms of selfhood and constrained ethics of neoliberal policies and philosophies in ways that would seem antithetical to the caring ethics normally associated with empathy (Slote, 2009). I argue that this results partly from the way in which power *still operates* in medical empathy and partly from the ways in which the limited focus on the patient-doctor dyad obscures the structural context in which healthcare occurs.

Interest in medical empathy is part of a more general movement to 'humanise' medicine, which has emerged in response concerns about the ways in which medical power and authority could displace or silence patient perspectives (Warner, 2011), and of the ways increasingly technical and technological medical practice could deflect attention from the patient's personhood (or, indeed, make the sick person wholly invisible, as their bodies – themselves increasingly rendered in terms of streams of data - displace and 'speak' for them (Mayes, 2009)). Empathy offered a means of shifting the doctor's awareness and intentions towards the patient's concerns. This was often represented via what we might term the 'medical empathy anecdote', persuasive mini narratives, in most of which an apparently difficult or obstreperous patient becomes successfully treatable once the doctor 'understands' the patient, and appreciates the reasons for his or her behavior and choices (Coulehan, 2004; Halpern, 2003). In these anecdotes, empathy is constructed as the opposite of medical paternalism. Instead of a doctor informing the patient of what is best for them, the doctor is required to reassess their own views about appropriate treatment, bringing their decisions more in line with the patient's outlook. As with patient centred care (and via much the same communicative means), empathy produces a convergence between ethical and medical objectives (Mayes, 2009).

But the medical empathy anecdote demonstrates equally clearly that empathy does not work to simply transfer power back to patients or to 'equalize' the patient-doctor relationship. Notionally about the legitimacy of patient perspectives, these anecdotes chiefly illustrate the superior virtue of the empathic physician and the successful enrollment of the patient in appropriate healing practices. They are *not* anecdotes of disruption, resistance or rejection of medicine on the part of the patient. As other scholars have noted, medical empathy involves ambivalent, uneasy and complex power relations, including the appropriation of the concept for instrumental medical purposes (Garden, 2007; Macnaughton, 2009; Pedersen, 2008). It may be desired by patients and have the capacity to destabilize the dominant modernist construction of biomedicine, but medical empathy serves equally to produce new forms of doctor-patient interaction in which the apparent autonomy of the patient is actually bounded and contained by the values and needs of biomedicine, including what is considered 'good' healing outcomes. Power relations are not eradicated in this scenario. Rather, they are rendered omnipresent, subtle and productive of new forms of selfhood and of patient-doctor relations. Mayes identifies this as Foucauldian 'pastoral power' in his analysis of the very similar context of patient centred care (Mayes, 2009) – a power that *produces* the patient as a confessing subject and *requires* that the doctor elicit, listen to, and ultimately interpret, the patient's 'story'. Confession – the patient narrative – becomes a means by which the doctor can help the patient tell the truth about him or herself (and receive and be complicit with appropriate therapy and healing as a result), in conformity with contemporary Western forms of subjectivity in which self-revelation and validation through confession are given primary importance. In this way the doctor can hold the patient 'in regard' (a gaze that may be less objectifying and more interactive than in older models of doctor-centred medicine, but is no less constituted through productive power for all that), and the patient, in turn, can become the vehicle for the exercise and display of the doctor's virtue (Garden, 2007).

In this way, empathy becomes chiefly (though not solely) the means for *enrolling* the patient in their own therapy, and for entangling ethical and medical objectives. Although each individual doctor cultivates empathy out of deep, passionate and abiding commitment to care for their patients, collectively, harnessed in research and normalized in medical training, it can become one of the array of instrumentalities that produce the efficient, effective and well regulated citizens that suit neoliberal fiscal policies – in this case, citizens who are limited from making excessive use of publicly funded medical resources. Empathy in medicine is admired for its capacity to maximize the efficiency of therapeutic outcomes, for ensuring, not so much compliance (which implies the old model of repressive medical paternalism) as self-regulated complicity in therapeutic benefit. Patients who arrived with diabetes produced by their own excesses of consumption can, through empathy, become reformed as patients who can self manage diet, behavior and medication to be responsible for their own health and place lower demands on publicly resourced health services (whilst allowing the market in consumables to flourish with little government regulation) (Lupton et al., 1997) (Hojat et al., 2011; Hojat et al., 2013).

Indeed, one of the continual dangers of current interest in compassion, empathy, kindness, narrative medicine and other forms of caring in medical practice is that they might become substitutes for adequately resourcing health services and collective public health policy outcry – not deliberately, of course. As recent governments have moved to strip away health services and funding, empathy can be utilized as the chief way of coping with the anger, resentment and distress of patients and their families as they navigate lengthy wait times, iatrogenic error and bureaucratic institutions. This is kind and humane, and serves the needs of health care staff faced with attempting to maximize addressing patient needs without

experiencing trauma and burnout themselves – but it simultaneously helps deflect that outrage from political expression.

This efficient empathy may appear as a competency that the skillful student will master appropriately, yet within the concept there still lurks uncontrolled emotion and intersubjective experience and hermeneutic co-construction, threatening to destabilise discourse and practice. Functional at 2 am in front of an obstreperous drunk patient after 16 hours of straight work, the SMS is not required to be conscious or capable of the silences, repressions, shifts in meaning, nuances or fine-grained ethical poise that Jamieson so poignantly writes of in her counter-narrative of enacting empathy. But her experience exceeds the discursive construction of efficient empathy nonetheless. And what would that imply about what empathy is, if not an instrument of efficient medical care?

5. Empathic subjectivities

The further one hunts through the extensive literature on empathy, the more the partialness of the way medicine uses the concept is revealed. Empathy in medicine is like a cartoon outline compared with the complexities of discussions of empathy in moral development, care ethics, therapy and intersubjectivity elsewhere. While other critiques of medical empathy have been especially concerned with how to treat affect – such as Garden's or Schertz's interest in the debates between David Hume and Adam Smith on sense-perception (Garden, 2007; Schertz, 2007), or Macnaughton's views on sympathy - my contribution to this discussion is to privilege the *epistemic* issues, and consequently to suggest that contemporary writers on medical empathy have lost sight of the fact that a century ago, there was a sophisticated and rich debate concerning empathy's status as knowledge. In many cases, the definitions writers on medical empathy mobilise – especially the oft-mentioned 'feeling into' – are those drawn from the past (Garden, 2007; Schertz, 2007). However, this is a past whose dimensions and contexts are elided in the process, or occasionally exclaimed over for being quaint and foreign (Hayward, 2005), rather than assessed for its implications for current discussion (Harrington, 2001; Zahavi, 2011) }(Svenaeus, 2014; Zahavi, 2015).

Where a history of the term 'empathy' is given at all, it is most often represented as an invention of Theodore Lipps'. '*Einfühlung*' or 'feeling into' is represented as an early form of emotional simulation or contagion (Coplan et al., 2011). This is already a slight misconception of Lipps's work, which was in fact primarily intended as a criticism of the analogical model of 'other minds', and who was therefore more concerned with epistemology than the word 'feeling' might indicate. It's an even more serious misconception of empathy's historical origins, which belong to phenomenology rather than to Lipps (no phenomenologist himself), as discussed below. Nonetheless the shorthand of feeling-into has tended to underpin debates in the medical literature about whether it is possible (or desirable) to 'share' a patient's feeling, and it continues to inform neurological studies of 'mirror neurons', infant mimicry and development, and emotional contagion (Coplan et al., 2011; Stueber, 2006, 2014).

Lately contemporary scholars of phenomenology have renewed analysis of the phenomenological approach to empathy – a philosophical tradition that, among other things, took the *embodied* aspects of human knowing seriously. (It is intriguing that medical concepts of empathy make no mention of the body whatsoever, despite the body being the focus of medical practice). Whilst I cannot here add to current philosophical debates about how empathy was understood and utilized a century ago, I will summarise content salient to

the current challenges in medical accounts of empathy.

The question of how we know anything at all has had many, many iterations. Early phenomenologists answered this question from the Humean perspective that all human knowledge is necessarily grounded in sense-perception. Lipp's concept of aesthetic response – *Einfühlung* – was in fact less a romantic expression of unity and more a fairly crude explanation of embodied response; he posited it as a process of involuntary, internal imitation, a tendency for the body to reproduce the movement of another entity, including artistic ones (so, the upward lift of an architectural column will tend to generate an 'inner uplift' in the observer (Zahavi, 2010; Zahavi, 2014)). Lipps' account was there to critique the assertion that we can only perceive other people as people-with-minds-like-ourselves through a process of analogical assumption and reasoning; he was counterclaiming that our grasp of other-minds is much more direct. While his critique was well regarded, Lipps' proto-simulationist model of empathy was roundly derided by phenomenologists; but nonetheless the debate sparked the theorization of empathy by Husserl, Stein, Scheler, Schutz and others, which informed and were shaped by the developing methods and philosophies of psychology and social sciences as they were debated and brought into being.

The core components of the phenomenological account of empathy from this period are: that *empathy is embodied*; that *empathy is interpretive and social*; that *empathy is experiential – but experience neither of 'direct' 'sharing' nor wholly imagined*; and that therefore *empathy is a crucial mode of understanding* (and 'understanding' is in turn a serious form of knowing). Together these comprise a rich account of intersubjectivity, which offers considerable potential for medicine.

Let us consider what thinking of empathy as embodied might imply. In the phenomenological tradition, *all knowledge* is necessarily and unavoidably embodied; humans only know anything through perception. But what is specific to and special about empathy is that it concerns how we perceive the body of the empathized-with-other. *Both* bodies are important. Discussions among leading phenomenologists in the early twentieth century agreed that they needed 'a theory that took empathy to be a special kind of perception of the psychical states *as they are manifest in bodily expression* (Zahavi, 2010).

In these accounts another person is never primarily mind or primarily body, but presents in a face to face encounter as an embodied self, what Scheler described as 'an expressive unity' (Scheler, 1954; Zahavi, 2010). Scheler saw affective states not as qualities of subjective experiences, but as *given in* bodily gestures and actions (through which they become visible to others), that is, given in expression. Husserl put it that what is directly given in perception is the body of the other, which is recognized as 'ensouled' (Makkreel, 1996). At the level of the natural science of psychology, Husserl proposes that empathy is a process of 'presentification', in which the subject apprehends a body as belonging to another *subject*. The concept of 'presentification', like 'intentionality', adds a quasi intuitive quality (intuition is another concept that Husserl explores carefully), that may not have the fulfilledness of a direct presentation but is not as indirect as imaginative representation. Understanding this requires addressing the other dimensions of empathy as social, as experience and as 'understanding'.

Both contemporary medical versions of empathy and phenomenological empathy from a century earlier agree that what is at stake is 'understanding' the *experiences* of *another*. Edith Stein, capturing the basis of the concept among phenomenologists, made it definitional*:* in her thesis, empathy is a form of intentionality directed at the experiences of

another (Stein, 1989; Zahavi, 2010; Zahavi, 2014). This need not be theorized restrictively as either direct *or* 'merely' inferential. If expressive phenomena (such as gestures, kisses, groans and so forth) are accepted as 'primary data' of perception, then the body of another is a field of expression that reveals for us the experiential life of that other, to which we have non-inferential access (Scheler, 1954; Zahavi, 2010). Meaning can be 'read' directly from the body just as one 'reads' meaning from words directly. We do not experience others precisely as they experience themselves; neither is self-experience the exclusive or determining model for other-experience; empathy is something more variable, complex and dynamic than either. Taking intersubjectivity and the body seriously in this way opens up the possibility for a doctor to have a meaningful, non-reductive grasp of embodied patient experience.

'Meaningful' is key here. Experience itself, as these phenomenologists understood it, is no naive ontological entity (which is how it so often appears in even sophisticated empirical research, such as characterizes so much of the 'illness experience' literature). Rather it arises as a result of the encounter between the empathizer and the empathized-with: that is, in a social circumstance. This *context* was intrinsic to phenomenological theories of empathy, but is utterly absent in medical accounts. Husserl's account is worth revisiting here because it is constructed around what can be 'seen' from different perspectives. Husserl wrote about empathy on two levels, those of the natural and of the human sciences – what he termed the 'naturalistic' and 'personalistic' attitudes. On the first level empathy can only indicate the experience of the other; but on the second, empathy becomes an understanding of the spiritual meaning of what motivates the other (Makkreel, 1996). By 'spiritual' he meant something like 'shared humanness' – shared via mutual participation in / creation of the social. Only by joint participation in a spiritual meaning world of social action do subjects become persons.

The unavoidable importance of social context was further explored by Schutz, who extended Husserl's and Stein's versions of empathy to argue that interpersonal understanding is heterogenous and requires, not only perception, but an appreciation of the *reasons* for experience, of meanings, motives and constraints (Schutz, 1967). Interpersonal understanding therefore requires both perception and interpretation, performed, in Schutz's view, via highly structured social contexts of meaning (Schutz, 1967; Zahavi, 2010). In some cases, therefore, we call on imagination or memory or theory in understanding others. These are not projections – experience is still co-intended and characterized by co-presence, and interpretive acts such as the use of imagination occur secondarily – but Schutz claims that empathy requires attending to the *shared motivational context* where the two subjects interact and affect each other in a face to face encounter (he termed this a 'we-relationship'). This context is multilayered, like the complex social world in which both subjects are situated and whose inferences and structures of meaning will determine how any form of interpersonal understanding develops. Schutz' account demonstrates that one can defend both the direct *and* contextual character of understanding at the same time, and it also indicates the incapacity of any single model of interpersonal understanding (such as the theory theory or the simulation theory of other minds (Stueber, 2014) (Stueber, 2006; Zahavi, 2011)) to adequately describe its varieties.

Thus the phenomenological account of empathy from this period requires that we take seriously both its 'direct', non-inferential, embodied character (which results from our own embodied subjectivity) *and* its hermeneutic, interpretive character (which results, not only from our being a different subject to the other, but from our co-location in a social context). 'Experience' speaks to both aspects; but what of 'understanding'? While empathy is

obviously a particular and particularly important form of understanding others, it comes very close to overlapping with *Verstehen* (as indeed it more or less does in Husserl's account), which has been a fundamental frame for sociological knowledge for a century (Weber, 1949). It offers a non-reductive, complex and multivalent grasp of the *meaning-world* of actors, making their activity visible in its accounts of events and phenomena, rather than treating human actors as objects acted upon by laws or factors. Husserl's version of empathy enables this sort of understanding by construing individuality as acquiring a distinctive totality of experience on the basis of common structures, whose existence and dimensions it is the scholar's work to ascertain. We might plausibly see Dilthey's Verstehen as an extension of Husserlian empathy in many ways, since it emphasized social context (mitwelt and umwelt) as a determinative frame in which the empathizing and empathized-with subjects are located, and in which subjects 're-experience' the experience of others by activating a structurally similar experiential nexus (Harrington, 2001).

Of course, later philosophers in the phenomenological tradition, notably Heidegger and Gadamer, reacted to Dilthey and his explication of Verstehen by arguing for an even less stable approach to ontology – a hermeneutics of facticity - emphasizing the temporality and finitude of *Dasein:* for them, understanding becomes less a methodological process but a possibility of being – not an outcome, but 'involved with' the process of understanding itself. That is, all knowledge is 'situated', as Haraway would put it. It should also be noted here that 'empathy' is related to and sometimes involves, but is not the same as, dialogue, 'clinical communication' or interaction in general (Usherwood) – the sorts of issues that were of interest to early social scientists, and the understanding of which is better described as falling more to the territory of *Verstehen*, or the many forms of symbolic interactionism which have been drawn on in research (though perhaps this is more a matter of emphasis than on technical distinction).

The phenomenological account has great potential for medicine. It validates the existence, importance and impact of empathy, and provides a more integrated and less factorial account of its subtle and multidimensional qualities. It restores the embodied nature of illness experience to analytic importance and doesn't require a strained separation between modernist polarities. It puts the empathizing doctor back into the picture and allows us to take her or his subjective experience and complex responses seriously, inflected as they will necessarily be by having both biomedical knowledge and a body, and by the performances of medicine. And it rightly allows us to see the co-constructed, hermeneutic character of empathic understanding as it emerges within a specific context (one that contains resource pressures and long waits and discursive expectations of appropriate roles and all the rest of it).

Such a hermeneutic approach to empathy fits well with works that show how the medical encounter is an interpretive event in any case (Svenaeus, 2001, 2014; Usherwood). Indeed we may speculate that it is precisely in its interpretive aspects that empathy exerts so much power, for example, via context effects (Arnold et al., 2014). It also suggests other potentials for practice: for how doctors can co-construct multivalent 'understandings' of illness and diseases, connected with personhood and with a more broadly interpretable embodied experience than is typically available in biomedicine. Technical questions – such as does this patient have a heart condition that requires medication – can be allowed to reveal their philosophical and social contours (the way a 'diagnosis' of high blood pressure can produce symptoms in a non symptomatic person, for example, or construct invalidism in a person who primarily values their physical autonomy). For those who find the heuristics useful, this account is functionally similar to (though more integrated than) the multi-factorial

psychological models of medical empathy, and raises interesting questions about the relationship between self, subjectivity and performance when considered in relation to those that advocate 'deep' and 'shallow' acting as a strategy for improving physician empathy via the very useful concept of emotional labour (Larson et al., 2005).

This is hardly the final word on the subject – I have written above of 'the' phenomenological account, but of course these are various, and they continue to evolve. One issue remains under debate, and that is the role of emotion and, in relation to this, the degree to which a division between empathy and sympathy is meaningful. An account of empathy that takes intersubjectivity seriously should function, as I've suggested, as a 'return of the repressed', the intrusion of an irreducible experiential model of understanding that makes nonsense of the polarities of modern biomedicine. The opposition between doctor and patient, mind and body, active and passive, knower and known, subject and object, technical and psychosocial dissolves, as it should: this 'whole person' perspective is part of what makes empathy both satisfying and enabling of insight. But where is emotion? It remains relatively untheorised, though very recent research is beginning to take the question up (Agosta, 2014; Zahavi, 2015). An intersubjective grasp of another's experience presumably involves and evokes emotion, although Zahavi argues, problematically in my view, that this is very limited (Zahavi, 2015). Others approach the question as affect rather than as emotion, and this is likely to fit better with an account of how empathy emerges and has impacts: because people are affected (Seigworth et al., 2010; Shouse, 2005). Agosta argues that a Heideggerian account of empathy would make affectedness a key feature of authentic empathic relationships (Agosta, 2014). In this context, empathy's distinction from sympathy becomes largely artificial (certainly not very useful for doctors) and the concern with preserving self-other relations less a matter of ontology than of performance (Downie et al., 2007).

6. Concluding empathy

Doctors and medical students are practical; they want to know what is possible and what tangible practices they can undertake. 'Efficient empathy' is compelling for the SMS because it does satisfy, and helps constitute, the best mutual construction of patient-produced and medically-produced benefits, and it allows the doctor to 'be themselves' – a doctor, with biomedical knowledge and instruments – to attain these. The SMS who is prepared to confront the complexities of interpersonal relations and to take philosophy seriously will likely find performative and process-oriented formulations of empathy, such as are accessible through models like that of emotional labour, most useful. But if its real power and importance lies somewhere in the non-reductive phenomenological realm, then, as Pedersen wrily comments, instrumentalist versions will necessarily miss their mark, at least some of the time.

This paper has argued that in ways much more powerful and much more egregious than Macnaughton commented on, medicine has indeed appropriated empathy for its own uses, perpetuating its own power/knowledge structures – including its discursive power. Medical empathy has been a construction in which all the forms of 'understanding' – subjective, interpretive, qualitative, contingent, contextual, unique, multivalent – are repressed and compartmentalized. It has been yet one more well intentioned and apparently beneficial norm that is in fact a construct and productive of neoliberal social order, in which appropriately regulated and efficient emotional relations between doctors and patients can deflect scrutiny of the systematic destruction of publicly funded medical care, not to mention the conditions of social inequity that are profoundly productive of illhealth in the

first place.

But yet the transformative potential of empathy continues to be compellingly experienced by both doctors and patients. Phenomenological accounts of empathy create a door through which the existential, affective, and semiotic aspects of illness can creep back in. A tension remains between this approach empathy and the critical reading that I've given in the Foucauldian tradition, further exploration of which awaits academic attention in the future. For now it still remains true that there are interactions between patients and doctors – momentary, dynamic, interpretive and responsive – that produce understanding that is so satisfying to both parties, as to constitute its own reward.

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