The art of medicine
The dangerous practice of empathy

An important role for the medical humanities is to stimulate imaginative insight into the lives and experience of others through literature and other art forms. The idea is that such exposure will develop “empathy” as an attribute useful in clinical practice. Those interested in medical humanities have promoted the importance of this concept, and the “practice of empathy” has become an icon of the growing medical humanities movement in the USA and the UK. US physicians have even gone so far as to adopt empathy as one of the accredited “skills” required by the American Council for Graduate Education. However, another crucial role of the medical humanities is to provide a critical watching brief on the way in which medicine can highjack complex ideas, confining and defining them in its own terms, and changing their meaning and impact. I would suggest that this has happened with the notion of empathy and that it is worthwhile examining the concept and discussing whether it makes sense to regard it as a clinical skill at all. I am not sure that empathy, in the sense of emotional identification, is possible. I also query the way that empathy has become an object of measurement among some physicians.

Both of these concerns (about definition and measurement) derive from a fundamental problem with the philosophy of human nature espoused by traditional medical practice: that of regarding the patient as an object whose physical being, psychological responses, and emotional experiences can all be broken down, accessed, and recorded. Even David Hume, who thought that a “science of man” was possible, was cautious about how knowledge was to be obtained. As he says in his *A Treatise of Human Nature*: “We ourselves are not only the beings, that reason, but also one of the objects, concerning which we reason.“

In clinical practice, the patient is the object of a physician’s scrutiny; the doctor maintains an objective distance. But empathy requires understanding of subjective experience: the patient feels something and the doctor should access comparable subjective feelings and “stand in the patient’s shoes”. This relationship, I would suggest, has to be one of subject and subject rather than object (patient) and subject (doctor). Some of the complexities become more apparent by considering empathy in psychotherapy. Carl Rogers advocated “person centred therapy”, an approach to psychotherapy which involves the therapist practising “congruence, empathy, and unconditional positive regard”. However, in developing his ideas, Rogers discussed the potential limitations of his view of empathy with the philosopher and theologian, Martin Buber. Buber’s view was that empathy was impossible in a therapeutic situation because of a mismatch of perspectives:

“You [the therapist] have necessarily another attitude to the situation than he [the patient] does…You are not equals and cannot be. You have the great task, self-imposed—a great self-imposed task to supplement this need of his and to do rather more than the normal situation.”

Buber argues that the problem for the clinician or therapist is one of keeping the patient in objective relation to himself because of his “great task”. In his book *I and Thou*, Buber describes his view of human connectedness. He distinguishes between

two modes of relationship, “I/Thou” and “I/It”. The former describes a relationship whereby two people encounter each other in an authentic way, without objectification of the other. “I/It” is his term for the kind of interaction that necessarily takes place in the clinic. One person meets the other not as a fellow being but as a conceptualisation or type of a person: as “doctor” or “patient”. A full experience of mutuality or understanding is not possible.

As clinicians we may regard patients as biochemical machines that need fixing; as wayward children who need to be led to eat correctly/stop smoking/exercise; as boxes of molecules to which we can add other corrective molecules. Mary Midgley in *Science and Poetry* characterises this way of seeing as “atomisation”. Clinicians atomise their patients (psychologically and physically) but at the same time are expected to relate to them as complete entities, or essences. This can require many shifts in perspective during the course of a single consultation.

If the kind of inter-relation that Buber describes is not appropriate for the clinical situation, does that mean empathy is not possible? Patients and doctors are physical beings who have some shared ideas of what it feels like to be in their bodies; to feel heat, cold, pain, or numbness. If I lay my cold hand upon a patient’s abdomen, I—as a person with skin sensitive to heat and cold—appreciate how my hand might feel and attempt to warm it or at least warn the patient that it might feel cold. However, as an emotional and cognitive being, what I am feeling and thinking is not apparent to the person who is with me. Their only access to my mind lies in what I say and how I look. As Edith Stein, a student of the Edmund Husserl, wrote in *The Problem of Empathy*:

“What another person experiences at a certain moment is not directly given to me. But the presence of the other is directly given, and so is the awareness that the other is an experiencing self. This cannot be compared with other modes…of experience. The experience of another is unique. This means that other modes of experiencing only are of partial help in explaining how the subjective becomes intersubjective. It also means that there is no doubt about who is experiencing primarily, and who is sharing, or experiencing, the experience of the other.”

It seems, then, that it is possible for us as clinicians to have some empathic understanding of what it might be like to be in someone’s shoes physically, but not psychologically. All that is possible psychologically is an awareness of the other as an experiencing being; and, if we are open enough and take time to ask, they can tell us what that experience is like.

But are we in danger of missing a lot if we do not have some access to, or understanding of, a patient’s “real identity”. Returning to the claims of medical humanities, is it possible for clinicians to draw understanding of the experiencing other from their own encounters in Buber’s “normal” situation, where two people interact without any therapeutic relationship turning one of them into objects?

Literary encounters would certainly not fulfil Buber’s requirement that intersubjectivity is the key to experiencing another person. The reader cannot experience intersubjectivity if she or he is not present in the world of the book. But although the reader is not physically present, an attentive reader can certainly be psychologically

present. In her autobiographical novel, *The Bell Jar*, Sylvia Plath's character, Esther, describes a severe depressive episode, unrelieved by sleep:

"I saw the days of the year stretching ahead like a series of bright, white boxes, and separating one box from another was sleep, like a black shade. Only for me, the long perspective of shades that set off one box from the next had suddenly snapped up, and I could see day after day after day glaring ahead of me like a white, broad, infinitely desolate avenue."

This masterful metaphor of the blinds induces fear with a sense of monotony and pointlessness—what the character herself must be feeling, in fact. As readers we have direct access to what is in the fictional character's mind: the writer is describing it for us. We have no such interpreter for the clinical situation. But it is important to exercise caution here. What readers experience in response to writing is not an authentic I/Thou experience. It is possible to shed tears in response to a particularly powerful passage, but then switch easily to the real world without the lingering distress that a real problem of this kind would cause.

I suspect that this is also the case for doctors' empathic responses to patients. I can be close to tears with a patient, but 10 minutes later engage in a light-hearted conversation with a colleague over coffee. The sadness, or fear, or whatever feeling I have experienced is not sustained, and is so different from what the patient is feeling that it seems disrespectful to suggest that I somehow participate in his or her experience.

I have suggested that true empathy derives from an experience of intersubjectivity and this cannot be achieved in the doctor–patient relationship. But all is not lost. Doctors do not need to feel the distress of their patients themselves to do something about it. We may have a momentary mirroring of that patient's feeling within us, but what we maintain is sympathy (feeling for not with the patient) and the need to respond. It is potentially dangerous and certainly unrealistic to suggest that we can really feel what someone else is feeling. It is dangerous because, outside the literary context, where we are allowed direct experience of what a fictional patient is feeling, we cannot gain direct access to what is going on in our patient's head. As Stein says, only "their presence is directly given"—so our assumptions may be wrong and our response may be based on a false assumption. Any mirroring of feeling will always differ quantitatively and qualitatively from that patient's experience. A doctor who responds to a patient's distress with "I understand how you feel" is likely, therefore, to be both resented by the patient and self-deceiving.

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