Empathy, Imagination, and Interpersonal Understanding in Medical Practice

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Abstract

Professional empathy in health care is a feeling with, about, and for the patient that opens up a world to be explored by way of imagination and dialogue. The concern is professional in nature because it deals with the patient precisely as a person the health care professional has the duty to aid in respect of her education and position. The biomedical paradigm needs to be balanced and combined in the clinical encounter with an empathic perspective, focusing upon the experiences and everyday life of the patient, since the doctor and other health care professionals meet not only with a potentially diseased biological organism, but also with a person who is suffering and in need of professional help.

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Introduction

Empathy with the patient in health care is an affective and cognitive process that opens up the experiences and situation of the patient to be explored by way of perception, imagination, and dialogue in the clinical encounter. The starting point for empathy is not the "medical body"—that is, the body understood as a set and system of biological functions in potential disorder—but the expressive "lived body," which serves as the anchoring point of the experienced world of the patient (Aho and Aho 2008; Carel 2008). Empathy is elicited by way of perceiving the lived, bodily suffering of the patient (body language and voice) and is continued by way of an imaginative attempt to feel and understand her predicament. Empathy is contextualized and enhanced by way of a dialogic exploration of the patient's suffering and lifeworld situation aimed at healing and/or helping him in a medical manner (Charon 2006). (To avoid the cumbersome "(s)he" and "her/his," the empathizer (for instance, a physician) will in this text be referred to as a "she," whereas the empathee (for instance, a patient) will be referred to as a "he.")

The biomedical paradigm needs to be balanced and combined in the clinical encounter with an empathic hermeneutic perspective, focusing upon the experiences and life story of the patient, since the doctor meets not only with a potentially diseased biological organism, but also with a person who is ill and suffering (Svenaeus 2022). Empathy is the point of entrance to the world of personally experienced illness that must be explored if health care personnel should be able to help their patients to a sufficient degree. For the doctor, as well as for other health care professionals, to not acknowledge or attempt to understand the patient as a person would not only be potentially unethical, but it would also be bad medical practice given the complex relationship that exists between diseases and illness experiences in medical diagnostics (Leder 2016; Svenaeus 2017).

The concern developed through empathy in medicine is a type of care for the patient as a person, who the health care professional has the duty to aid in respect of her education and position. The patient is therefore not a friend in private, but he is nevertheless a person whose feelings, experiences, and situation the professional feels herself into in an empathic process by way of concern. Such professional concern can lead to feelings of pain and helplessness on the part of the health care professional, and in such cases empathy becomes detrimental to good care (Gleichgerrcht and Decety 2012). But it need not do so if health care professionals are offered adequate training and knowledge about the empathy process, sufficient time to meet their patients and respond to their needs in a dialogue, and are provided with the opportunity to reflect upon their own feelings with other professionals (Agosta 2014).

The History of Empathy and Sympathy

Empathy is a translation of the German term "Einfühlung," which dates back to German idealism and hermeneutics in the early nineteenth century, and means "feeling oneself into." In the late nineteenth century, the term was used to describe

aesthetic experiences of "animating" works of art by projecting oneself into depicted landscapes, feeling the expressive features of nature by way of projection. The idea quickly migrated into the recently formed discipline of empirical psychology in which the object of attention were experiences of other persons, which the empathizer would feel herself into by way of such projections. The most well-known psychologist to make use of and elaborate on the concept of empathy around the turn of the previous century was Theodor Lipps (Stueber 2006, 5 ff.). Even more important were the studies by philosophers Max Scheler (2009) and Edith Stein (1989), written in the 1910s, which are main inspirations for the phenomenological model of empathy in health care found in this chapter (Svenaeus 2016, 2017).

As empirical psychology spread to the English-speaking parts of the world, different translations for "Einfühlung" were suggested—"aesthetic sympathy," "semblance," and "animation"—until 1908 when Edward B. Titchener coined the new term "empathy" (from the Greek "empatheia"), which was quickly accepted and developed into a much-used concept with a slightly different meaning than the German term (Lanzoni 2018, 9 ff.). Empathy came to denote an ability of attaining another person's point of view by way of an imaginative process, rather than a projection of one's own feelings to make his perspective come alive. With this slightly different meaning, the term was actually retranslated into German as "Empathie" in the 1950s (Lanzoni 2018, 12).

To complicate things further, there already existed a term in the English language to describe empathy-like processes, namely, "sympathy," which was used by empiricist philosophers David Hume and Adam Smith already in the eighteenth century, to describe attempts to understand the other person's predicament as well as feeling for him. Sympathy was then translated in the nineteenth century into German as "Sympathie," which was used more or less interchangeably with the older word "Mitleid," "to suffer with," which, in turn, comes close to the English terms "compassion" and "pity," which have also been around for a longer time (Lanzoni 2018, 5 ff.). It is crucial to keep this history of intermingling terms in mind when approaching the contemporary use of the term "empathy" in medicine which is far from consistent and coherent. Empathy is generally looked upon as an essential ability and skill in modern clinical medicine, whereas sympathy and compassion—not only feeling oneself into the patient's point of view, but also feeling with and for him—are generally viewed with suspicion (Gerdes 2011). Health care professionals who are not only empathic but also sympathetic run the risk of becoming unprofessional in the encounter with the patient and developing so-called compassion fatigue or burnout, or, at least, so the story goes (Gleichgerrcht and Decety 2012).

Despite such attempts to safeguard empathy from sympathy in modern medicine, empathy never was and never will be a cold mind reading process but relies on feelings of concern developed in the meeting with the patient. Empathy feelings are often defined as the feelings and adjacent thoughts that make the empathizer see the empathee's (the person who is empathized with) point of view, but such perspective taking always relies on some kind of felt concern for the empathee and his predicament (Halpern 2001). In order to explain why this must be the case, it is necessary to say a bit more about contemporary empathy research in fields adjacent to medicine and health care.

Contemporary Empathy Research

In a seminal paper—"These things called empathy: Eight related but distinct phenomena"—social psychologist C. Daniel Batson notes that the term is currently used to denote many different things in the multidisciplinary field of empathy research, namely, 1. empathy as knowing another person's internal state; 2. empathy as matching the posture of the other; 3. empathy as coming to feel what the other feels; 4. empathy as projecting oneself into the other's situation; 5. empathy as imagining how another person is thinking and feeling; 6. empathy as imagining how one would think in the other's place; 7. empathy as feeling distress at witnessing the other's suffering; and 8. empathy as feeling for another person who is suffering (Batson 2009, 4–6). Some of these meanings of empathy are rather similar, but some are also strikingly different (see, also, further, the chapters in Maibom 2017).

Batson specifies two questions that researchers invoke empathy to provide an answer to (and from the questions follow the eight different definitions): "How can one know what another person is thinking and feeling?" and "What leads one person to respond with sensitivity and care to the suffering of another?" (Batson 2009, 3). By way of these questions and definitions, one recognizes the etymologies of the terms empathy and sympathy surveyed above. Questions about how to investigate the feelings and thoughts of the other person (1–6) expand to questions about caring for his well-being (7 and 8). The concept of empathy thereby takes on a meaning that includes a feeling for the other person, an aspect of empathy also named sympathy or compassion, as we have seen above. In the definitions of empathy in terms of isomorphic feelings (2 and 3), empathy also comes close to what is known as "emotional contagion," a process in which a person is influenced by the feelings of other persons without necessarily being aware of this influence (Hatfield et al. 2012). The process of emotional contagion is often explained by way of references to our neural anatomy, notably to what has become known as "mirror neurons," which were discovered in the 1980s (Hickok 2014).

Mirror neurons are defined as neurons that fire not only when a person does something but also when she sees or hears somebody else doing similar things. Mirror neurons in such a way make it easier for us to feel and understand the bodily expressions and actions of other persons without having to form thoughts and hypotheses about them in a mind-reading manner. Furthermore, the neurological research on empathy has identified other types of neural connectivity in areas of the cortex and the limbic system which are linked to social behaviors (Decety and Jackson 2004; Engen and Singer 2012; Shamay-Tsoory 2009). These areas of the brain involve not only mirror neurons, linked to different sensory systems, but also neural structures initiating feelings in situations that typically call for a quick emotional response (what is called somatic markers) and structures involved in face recognition and the expression of language (Damasio 1999). Many of these networks of neurons contribute to what is called "shared representation," which means that they automatically activate the same neural circuits when someone does or feel something, as when she watches somebody else doing or feeling the same thing, or even when she imagines or remembers someone doing or feeling the same thing (Rizolatti and Sinigaglia 2008).

The empathy researchers attempting to answer the first question listed by Batson—How can one know what another person is thinking and feeling?—were inspired by the mirror neuron findings to understand the empathy process in terms of direct perception and simulation, rather than thought-dependent mind reading. A person does not understand another person as being in a certain state of mind because she forms a theory about his facial expression and body language based on an analogy with herself, but because she perceives his expressions directly and by way of projection understands them to be his feelings rather than her own. As made obvious from the short survey above, empathy as this ability of perceiving and imagining the other person's perspective on the world has a long history in philosophy and psychology that was made convincing and plausible again by the discovery of mirror neurons and as a result gained new influence in the philosophy of mind and social psychology from the 1990s and onward (Lanzoni 2018).

Empathy researchers attempting to answer the second question by Batson—what leads one person to respond with sensitivity and care to the suffering of another?—were also greatly inspired by the mirror neuron findings, but in this case the interpretation stressed not only how these neurons make us understand other people but also about how they make us care for them (Baron-Cohen 2011; de Waal 2009). A common critique of such an understanding of empathy (including not only 1, 2, 5, and 6, but also 3, 4, 7, and 8 on Batson's list) is that it is unable to articulate how empathy is not only similar to but also different from emotional contagion and sympathy, at least in some cases (Gerdes 2011). A popular idea of empathy-sympathy theorists is the so-called "Russian doll model" according to which empathy is developed (through the history of evolution and in the individual) as a series of layers grown on top of each other, starting out with mirroring processes and developing into feelings of concern for and thoughts about the predicament of others (de Waal 2009, 208–209).

In the second group of researchers, the term empathy has been employed to include sympathy (sometimes named compassion). That is, the understanding of the other person brought about by way of empathy includes a feeling of concern for him, and the resulting understanding will motivate the empathizer to help the empathee (Batson 2012; Hoffmann 2000). In contrast to this approach, researchers in the first group have been busy with trying to separate empathy from sympathy and related concepts. Empathy does not necessarily include or result in any warm feelings of concern but is essentially a form of knowledge about the other person targeting what he is feeling or thinking, they claim (Goldman 2006; Zahavi 2011).

Acknowledging the risks of employing an overinclusive or imprecise definition of empathy (Coplan and Goldie 2011), the best solution is probably to insist on empathy as something beyond mere perception (Zahavi 2011), or cold mind reading (Goldman 2006), precisely because of its *emotional* character (Svenaeus 2016). Empathy is not the same thing as emotional contagion, since it demands more than that, but it typically starts by way of contagion and makes use of such preconscious processes. Empathy is not the same thing as sympathy (or compassion), but it typically leads to sympathy, and it involves a form of emotional *concern* for the other person from the very start. Empathy starts as a direct perception of the other

person's feelings, but it is developed into an imaginative and/or dialogic attempt to find out why he is feeling in particular ways and what might be done about it. Using a terminology often employed by empathy researchers, cognitive empathy (forming thoughts about the perspective of the other person) always rests upon affective empathy, both in the sense of tuning in to the feelings of the other person more or less unconsciously (emotional contagion) and in the sense of feeling concern for her well-being (Halpern 2014).

The Phenomenology of Empathy

Empathy is typically elicited when encountering persons expressing noticeable feelings, often associated with suffering. A good example is encountering a person who is in bodily pain. Watching him, we immediately feel something similar to pain, and by way of this automated process we also feel an urge to act in order to relieve the pain in question. In the course of fractions of a second, we realize that the pain-like feeling we are experiencing is a result, not of ourselves being injured, but of witnessing the other person in pain, and in this process the primary mirroring feeling is turned into an *understanding* of the other person's feeling and situation that can become more sophisticated by way of various imaginative undertakings and by interacting with him. In this process, the primary urge to act to relieve suffering found already on the automated level will typically be turned into an experience of sympathy, a feeling *for* the other person, and possibly, also, an attempt to do something to help him.

A blueprint for such a phenomenological theory of empathy is found already in Edith Stein's doctoral dissertation in philosophy from 1916 *On the Problem of Empathy* (Stein 1989, 10). Stein takes empathy to be a three-step process in which the experiences of the empathee: (A) emerge to the empathizer as meaningful in her perception of him; the empathizer then (B) fulfills an explication of these experiences by following them through in an imaginative account guided by the empathee, in order to (C) return to a more comprehensive understanding of the experiences in question. The steps that Stein discerns in the empathy process could possibly be reiterated—step C could serve as a new step A and so on—but they could also be supplemented by other ways of engaging with the empathee, such as talking to him or starting to do something for/to him or together with him. These ways of human interaction transform empathy as a perceptual and imaginative endeavor into hermeneutically and morally reflected forms of understanding and dealing with the other person.

However, even though Stein restricts the empathy process to the three-step model specified above—steps that do not include conversation and coordinated actions between the parties—a form of tacit communication is arguably present already in the empathy process as such, provided the empathee recognizes that he is being empathized with and therefore directs his expressive behavior toward the empathizer in the process. And the empathic feeling-oneself-into the experiences of the other person will be at work also in many "empathy plus" forms of human interactions,

which, in addition to perception and imagination, also involve the talking, listening, and acting together in the world of persons (Svenaeus 2016, 2018).

Empathy consequently starts with a preconscious feeling *with* the other person, in the sense that the empathizer is tuned in to a similar feeling when she perceives the empathee's bodily expression, which then turns into an emotion *about* the empathee's feeling, which, at least in the standard case, also turns into a feeling *for* him. Sympathy standardly makes the empathizer take action in order to help, provided she does not act on competing impulses or intentions that prevent her from doing so. Consequently, empathy is not the same thing as emotional contagion or sympathy, but it includes a primary *caring* for the other person in the sense that an impulse to help is part of the empathy process from the very start. The empathizer's feelings are guided by way of a concern, and this concern provides the empathy process with *energy* to seek reasons for *why* the empathee is feeling bad (or in some other way). This more sophisticated empathetic understanding will give rise to new forms of concern, and so on. Empathy is thus always motivated and driven by some form of caring for the person it is about; in the case of health care, we can talk about a "professional concern," to which I will return below.

The model of interlinked feelings *with*, *about,* and *for* the other person explains why "being empathic" in everyday understanding most often is used as a shorthand for being morally good, whereas lacking empathy is viewed as a moral defect (Battaly 2011). In contrast to this, researchers of empathy answering the question of how one can know what another person is thinking and feeling most often want to keep the empathic and the moral realm separate (Batson 2009). Getting to know the predicament of the other person is not the same thing as reaching the conclusion that one ought to help him or take action to do so, they point out (Prinz 2011). It is possible to reach the conclusion that the other person *deserves* his suffering, or one may fail to help because one is a coward, an egoist, or too distressed at the present moment. An example that is often brought up in order to show that one can exercise empathy without any moral concern whatsoever is the psychopath, who ruthlessly exploits the suffering of other persons for his own gain and perhaps even sadistic pleasure. More common than such forms of emotional exploitation behaviors are examples in which the distress felt facing (or hearing or reading about) suffering others lead to avoidance behaviors rather than to sympathy and altruistic actions (Eisenberg and Eggum 2009).

The success of continued empathic engagements depend upon the extent to which the empathizer is able to tune in to the experiences and contextual horizon of the empathee by caring about his predicament in various ways. The feeling-with the other person consequently goes far beyond emotional contagion and is basically a way of joining moods that make a shared "being-in-the-world" possible (Heidegger 1996, 117 ff.). Matthew Ratcliffe has analyzed the role played by fundamental moods, which he calls "existential feelings," in providing a basic sense of belonging to the world, and he has stressed the importance of shared moods for empathic understanding (Ratcliffe 2012). If I am not able to tune in to the world of the other person because his existential predicament is too foreign to me, for instance, if he is severely depressed or has a very different cultural background, then I will not be able to empathize with him, and neither will he with me (Ratcliffe 2014). The ways we

are attuned and our abilities to tune in to each other are immensely important for our possibilities to understand each other in everyday life, and, also, in health care settings (Svenaeus 2017).

Emotional Empathy and Sympathy

Emotions present things that happen in the world around us—and other people are part of this everyday world—by way of feelings. When I go through an emotional experience, I feel it in my body, although in many cases I am not *focused* on the bodily sensations in question. This is no coincidence, since the emotional experience is directed toward something in the world that is made present to me in a vivid and attention-consuming way through the feeling in question—a thing I am afraid of or ashamed of, or happy or curious about, for example (Goldie 2000). Emotions are not merely beliefs about how things in the world are (and ought to be), typically accompanied by bodily feelings; they are ways of judging the world in perception *by way of feelings* that are anchored in the body (Colombetti 2014). The objects of empathic emotions are precisely the feelings, actions, intentions, and situations of other persons that we explore and judge to be such-and-such through empathic experiences.

Empathy is not a special form of emotion in the sense that it feels in one certain way, in contrast to other ways of feeling things to be such-and-such in the world. The empathizer can find herself in many different types of feelings when she goes through empathic emotions, in perceiving and interpreting the empathee to have such-and-such experiences. She may be angry, sad, joyful, worried, or curious when she is empathizing with the other person, to mention some common examples. Some types of feelings are particularly hard to combine with empathy, since they tend to preclude the gearing of attention toward the experiences of the other—the move that makes the emotion in question empathic. Boredom is an obvious example of this, and so is fear. If I am bored—in general, or with the other—it is hard for me to empathize with him. If I am frightened—in general, or, particularly, if I am frightened *of him*—it is even harder for me to direct my attention toward the experiences he is having (and the reasons for them) because all my attention is consumed by the project of protecting myself from his anger and threat. Such empathy-aversive feelings are not only common in everyday life but also in health care when professionals encounter patients they find it particularly hard to empathize with, such as depressed, manipulative, or aggressive patients.

A direct perception of other persons without any explicit feelings of sympathy for them is, indeed, perfectly possible, as already Max Scheler pointed out in his classic work *The Nature of Sympathy* from 1913 (Scheler 2009, 9). This does not only apply for the sadist but also in situations in which the empathizer is too distressed to engage or feels aversion for the empathee for some reason. However, the moment the type of geared attention stressed by Edith Stein transforms mere perception into empathy, there will also be a *concern* involved that motivates the empathizer to explore the experiences of the empathee by way of imagination (Stein 1989, 16). If no such concern enters the scene, the perception of the other person's experiences will not

develop into an act of empathy, because there is no *felt urge* to focus one's attention upon the experiences of the other in a deepened exploration of his predicament. In such nonempathic situations, we may perceive and judge other persons, maybe we even do things together with them, but we are not engaged in empathy because the focus of our attention is not the feelings and experiences of other persons, but instead something else we are trying to bring about in a social setting.

The relationship between empathy and sympathy is dynamic, because not only does sympathy provide a motivation and a way for empathy, so does empathy for sympathy. In the empathy process, I typically come to care more about the other person as I find out more about his predicament. However, in some cases, finding out more about the empathee's predicament may lead me to the conclusion and feeling that he deserves his suffering. In a manner akin to the sadist, I may even feel *good* about his suffering (say I am witnessing a rapist being beaten up by his victim). In such cases, empathy with the other person's experiences is admittedly not joined by any sympathy, but it is, nevertheless, typically joined by a kind of *negative concern* for the person in question. The sadist *wants* his victim to suffer because her suffering is his pleasure, and I may in turn want the sadist to suffer because I think he deserves it.

What about cold mind-reading empathy, sometimes ascribed to psychopaths? Psychopaths are often said to *know* exactly what the weak spots of victims are to exploit—perhaps even by torturing them—without feeling any regard or remorse. How do they attain this knowledge if they are not feeling anything for their victims? Does this case not prove that empathy and sympathy are essentially different in nature? Does it not prove that feeling oneself into the experiences of the other person can be done without any feelings with and for her? However, it is doubtful that such examples of cold and cruel empathy really exist outside Hollywood. Persons diagnosed with antisocial personality disorder (the scientific name for psychopathy) are rather persons who feel no concern for other human beings whatsoever and therefore do not empathize with them, either (Baron-Cohen 2011, 75–84). Psychopaths are selfish, fearless, and strategic, but they do not engage in empathy precisely because they do not care about others. Perhaps some psychopaths do empathize in the way sadists do, but, if so, they use their *sadistic concern* rather than being cold in the sense of lacking feelings. Other psychiatric examples of inability to empathize are autism spectrum disorders, in which patients have difficulties to feel themselves into the experiences of other persons and understand them but are neither cruel nor cold-minded (Ramachandran and Oberman 2006). In autism, the basic skill lacking is rather the ability to spontaneously tune into the world of the other person by way of feelings, not the ability to feel concern for the other as such (what is sometimes lacking in personality disorders).

Professional Empathy

It is sometimes claimed that empathy with minimal concern is the type of empathy that doctors, nurses, psychotherapists, and social workers employ (or should employ) when helping their patients/clients (Gleichgerrcht and Decety 2012).

However, such ways of making empathy more professional in nature throws the baby out with the bathwater. Doctors, nurses, psychotherapists, and social workers *do* feel concern for their patients/clients in attempting to help them, and they *should* do so. They must be able to control and modify the nature of this concern in order not to become unprofessional or suffer burnout as a result of it, but this does not mean that they adopt a cold mind-reading attitude as a result of this modification, or that an emotionally neutral attitude would ever be enough to make them good professionals. In fact, such an attitude, while sometimes allowing good science to be done, would immediately put the practice at risk for unethical treading precisely because of the lack of empathy (Halpern 2001).

Professional empathy for the patient in health care is a feeling with, about, and for him that opens up a world to be explored by way of imagination and dialogue. The concern is professional in nature because it deals with the patient precisely as a person the health care professional has the duty to aid in respect of her education and position. The patient is not a friend in private, but he is nevertheless exactly *a person* whose feelings, experiences, and situation the professional feels herself into in an empathic process by way of concern. As elaborated above, the most basic form of concern for the other person is enacted as a feeling *with* him in being *touched* by his suffering (bodily and facial expressions) through resonance processes brought about by way of mirror neurons and other features or neural anatomy. This primitive form of sympathy takes its starting point in emotional contagion, but as soon as the empathizer realizes that the source of her feelings is the empathee and not herself, the possibilities of empathy open up. If the empathizer shies away and relieves her feelings of distress by looking after herself rather than the other person, the empathic possibilities are not realized. If, on the other hand, the concern becomes other-directed, empathy is initiated and can be developed in various ways: through continued attention on the expressions of the other person and through attempts to interact with him and/or imaginatively step into his perspective.

If feeling-with is the starting point for empathy, in health care as well as in other forms of practices, dialogue and narrative may be thought about as the main paths in bringing empathy forward and making it "thicker" with respect to understanding the patient. The best way to understand the world of the other person (his feelings, thoughts, situation, etc.) is a dialogic engagement with parts and aspects of his life story (Gallagher 2012). Medical practice and meetings between patients and professionals in health care are dependent upon such an interpersonal understanding, which is framed by the mission to help and cure (Svenaeus 2022).

The concern for the other person that joins empathy from the very start should never make us forget that we are *different* from other persons in many respects. Empathic imagination needs to be followed up by dialogue to prevent ending up imagining *oneself* in the other person's situation rather than imagining what it would be like to be *him*. Consequently, empathy is not only a feeling of the other person's feeling, but it is also a way of *responding* to his feelings by way of imagination and dialogue. The interpersonal understanding we are able to develop on the basis of empathy is best thought about as a form of *hermeneutics*, as Martin Heidegger acknowledged, even though he and other phenomenological philosophers, such as

Hans-Georg Gadamer, hesitated to make use of the term empathy (*Einfühlung*) because of its association with a Cartesian model of the mind (Stueber 2006, 204 ff). We do not feel ourselves into the life of the other person by way of finding a door to his enclosed house of mind; we feel together-about-and-for him in sharing a world and trying to find out how *he*, particularly, fits into the picture. This is how empathy works, in health care as well as in other essential human encounters.

Empathy in Health Care: A Summing Up

In what way is the phenomenological model of professional empathy outlined above important to good medical practice and ethics? In several ways, already touched upon in this chapter, that will now be summed up.

First, the phenomenological model makes obvious that empathy happens in the embodied, experiential meeting between two human beings. Empathy in medical practice will therefore be hard or even impossible to achieve if the meeting is conceptualized and enacted as the pure processing of information (the computer-program doctor or medical meetings via chats on the Internet). Empathy is primarily an attuned perception of the experiences of the other person that appears in the face-to-face meeting. Information technologies may be used to complement the medical meeting but never to fully replace it.

Second, the emphasis on the experiences of the patient, as they appear to the professional in the clinical meeting and emotionally pull her to imaginatively go along with the patient, stresses the importance of the lived body and lifeworld of the patient in medical practice. This emphasis is of great importance for contemporary medicine that is dominated by a natural-scientific paradigm by which the illness perspective and personal voice of the patient are constantly threatened to be marginalized as allegedly "non-scientific" or "merely subjective" in character. The claims for enhanced patient autonomy and a personalized medicine voiced in contemporary health care are not sufficient to remedy this one-sidedness, since the autonomous, personalized patient is too often viewed as a consumer of health care to be educated and empowered, rather than as a needful, suffering human being to be helped and understood by the professional.

Third, the three-step model of empathy described in this chapter paves the way for sympathy as a possible result of, and also, a driving, caring force of the empathy process. The concern for the other person is that which makes the health care professional develop an interest for the patient in an emotional manner. The professional cares for the patient, and because of this she wants to know more about his predicament (experiences), which in turn will make her better prepared to help him. An empathic concern for the patient that is authentic but still professional in character is the starting and founding ground for good medical practice.

Fourth, empathy paves the way for dialogue and human interaction, and it remains present in the very kernel of the dialogues that are performed in order to explore the experiences of one of the parties (the patient in the case of health care). Empathic dialogue—verbal and nonverbal—is no doubt the core, which the medical

meeting revolves around. Scientific investigations of the biological body must be anchored in the empathic dialogue, and the medical findings must be interpreted and turned into diagnoses and prognoses with the lived illness perspective in view.

Fifth, by way of the empathy-sympathy analysis a basic virtue of the health care professional is substantialized and framed: to stay open to and care for the patient and explore his experiential world. This virtue, which one could call professional compassion, is clearly essential to be able to form good clinical judgments, which is the essential skill of health care professionals. The hermeneutics of medicine starts off with empathy and returns to empathy when taking decisions about treatments and giving medical advice.

Sixth and finally, a phenomenological analysis shows how empathy can serve as a foundation for medical ethics, since it starts off in the archetypical situation of being faced with the suffering of another person, who is in need of help. Empathy provides an emotional gateway to a more developed form of knowledge about the experiences of the other person, and it also makes us care for him. The empathy-sympathy process found at work in the medical meeting can therefore serve as an anchor point for medical ethics and show how health care activities are not to be thought about merely as business transactions or deliverance of utilities in accord with justice claims. To be empathic not only means to respect the other person's autonomy, but it also means to insist that we are forged together by duties to help each other that are felt to the bone, particularly so in medical practice and health care.

Definition of Key Terms

Phenomenology: the study of the first- and second-person perspectives of everyday experience in contrast to the third-person perspective of empirical science

Hermeneutics: the study of the first- and second-person perspective as they appear from the point of view of language, dialogue, and interpretation

Lived body: the body-subject who inhabits the lifeworld and expresses feelings by way of emotions

Life world: the everyday world as it appears from the lived-bodily point of view

Empathy: a feeling oneself into the other person's experiences, imagining what it would be like to be in his situation

Emotional contagion: a being influenced by the feelings of the other person

Sympathy/compassion: a feeling of positive concern for the other person

Empathizer: the person who empathizes with another person

Empathee: the person who is being empathized with

Summary Points

- Empathy is a feeling with, about, and for the other person and his experiences, starting out in a face-to-face meeting.

- Empathy is always fueled by a concern for the other person's predicament, which provides the motivation for engaging with him.
- Empathy is an emotional experience that includes an imaginative endeavor to understand the other person's situation.
- Empathy is both affective and cognitive in nature; it operates on different levels and in standard cases leads to intervening actions.
- Empathy is different from emotional contagion and sympathy/compassion, but it is most often elicited by contagion and usually leads to sympathy.
- Empathy forms the gateway to dialogue and interpersonal understanding in health care.
- Empathy in health care rests on a professional concern felt for the suffering patient.
- Empathy in health care leads to increased knowledge about the experiences and everyday life situation of the patient necessary for making a correct diagnosis and finding out what to do in the individual case.
- Empathy is the anchoring point for good medical practice and health care ethics.

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