Chapter 8
What Is Meant by ‘Empathy’?

Education for Communication Must Go Deeper Than ‘Skills’

Chapter 2 described ‘empathy decline’ as a significant undesired effect of a technical medical education and as contributing factor to the overall problem of communication hypocompetence in medicine. But ‘empathy’ is a complex notion that needs to be further discussed and unravelled. Debates surrounding what we mean by ‘empathy’ can coalesce to form a case study for progressing our thinking about communication beyond the current, dominant reductive models of instrumental skills or competences.

If we reduced our complex, aesthetic, and ethical everyday communications to instrumental ‘competences’, there would be no need for literature, cinema, opera, and drama; no need for character studies, television soap operas, or reality television shows to provide a mirror showing how inventive, subtle, and complex (and far from equilibrium) much of our communication is—whether everyday or in professional settings. There would be no need for comedians—especially satirists—or media commentary in such an instrumental world; no need for actor patients, dramaturgical or depth-psychological models of interaction. Why then do we not see professional relationships as equally complex, unstable issues in need of a complex response, including a complex educational response?

We will not make a case *for* empathy, but use ‘empathy’ as a case study for illustrating the demise of serious thinking about communication in professional relationships. While a body of research evidence highlights areas for intensive attention in doctor–patient communication, just *how* we educate such ability is contested. In undergraduate education, as already noted, focus has developed on ‘training’ communication as a set of atomized skills. For example, Rider and Keefer (2006) describe a defined set of ‘communication skills competencies’ linked to a ‘teaching toolbox’—the toolbox metaphor sitting comfortably within the technical–rational approach—as if instrumentalizing communication ‘solves’ the ‘problem’ of how we teach communication.

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The argument is circular. If we frame communication as a 'problem' to be solved and as a set of competences to be performed, then we *produce* communication within the parameters of our definition and we produce conforming identities of 'communicators' who follow this pattern. When things go wrong, we fix them, our toolbox at the ready. Indeed, the metaphor is explicitly mechanical, implying a linear set of cogs, where communication between persons (and machines) may be better described as non-linear—as an embodied, complex, adaptive, dynamic system (see Chap. 15).

This is not to say that medical students should not formally learn how to communicate effectively with patients—the professional context offers challenges that everyday communication does not (e.g. limits of intimacy) and some students will be strongly invested in a disease-centred model of medicine from the outset of their studies. Rather, given the deep ambiguities inherent to communication and the *absences* that are referred to throughout this chapter (such as unconscious dynamics, indirections, and purposefully ambiguous, 'open-ended' communications that allow for 'face saving'), perhaps communication may be better learned as a post hoc exercise. Research indicates that this is best achieved through structured, well-facilitated, small group reflection on actual experiences with patients (Branch, 2001; Quirk, 2006).

These reflective experiences can be offered in various ways—within the work placement as uniprofessional settings or multiprofessional groups or as a regular 'mop up' of what has been experienced in clinical settings, with uniprofessional or multiprofessional facilitation. This has possible consequences for protecting patients from potential harm through miscommunications by students, but the advantages far outweigh these possible disadvantages, where, ideally, students learn to communicate in a formative, supportive setting (Benbassat & Baumal, 2009) that mirrors supervisory and mentorial networks familiar to counsellors, psychotherapists, psychiatrists, and clinical psychologists.

This means placing less emphasis on preparation for practice through the currently dominant, largely instrumental, methods of communication skills training (CST) in simulated settings. The dangers of the instrumental approach are that (1) 'communication' is reduced to a list or tick box, (2) the simulated patient offers an out-of-context 'standardized' experience, and (3) the unexpected is controlled or introduced as a purely theatrical device by an actor-patient (Benbassat & Baumal, 2009; Bligh & Bleakley, 2006).

A 1998 survey of communication skills provision in the UK schools of medicine (Hargie, Dickson, Boohan, & Hughes, 1998, p. 25) showed 'considerable variability in such areas as course content, timing, duration and assessment'. The survey notes 'lack of adequate physical resources and suitably trained staff' with lack of forward planning in terms of curriculum development in this area. A follow-up survey in 2010, following a General Medical Council (GMC) curriculum mandate that required all UK medical schools to provide communication skills 'training' and to identify a lead within the core academic staff, showed far greater consistency across schools' provision, leading to what the authors term a 'modal' model of CST

(Hargie, Boohan, McCoy, & Murphy, 2010, p. 385). The authors note, however, that 'wide variations remain in CST pedagogy'.

It is likely that the next decade will see such variations in pedagogy smoothed out, as CST becomes packaged, involving standard exercises for so-called skills such as empathic listening. Standardization, however, can soon devolve to homogenization. Central to standardization is location—purpose-built clinical skills 'laboratories' and dedicated 'communication suites' with video feedback facilities. Foucault's (1975) work on subtle institutional forms of the uses of power for regulation is readily applicable to the standardized communication suite. Here, the central 'all-seeing eye', or panopticon, is explicitly at work—as the regulatory gaze of the video camera, of the assessor sitting in another room watching (being) the 'monitor', and of the actor-patient who cannot slip fully into role because he or she is also assessing the student and must maintain the assessor's gaze or scrutiny.

Under the guise of a 'safe' environment, in which communication can be tested on actor-patients with videotaped feedback from experts, we then see an explicit form of surveillance and control, which comes to shape a docile identity. Here, we see the more sinister purposes for which such suites are built—not so much educational, in promoting the creative production of knowledge, but regulatory, in promoting the reproduction of docile behaviour. The symptom is evident in the index of Roter and Hall's (2006) primary text, where there are six entries on 'nodding' (the key surface text for empathic listening, but so readily open to dissimulation by the student), but nothing on messy and complex psychodynamics such as transference or resistance. Emotionally charged words such as 'desire' and 'repulsion' are noticeably absent, as are commonly met responses such as lukewarm 'boredom' and icy 'disinterest'.

Just as rigid prescribing to patients by doctors without establishing dialogue and understanding leads to forms of resistance, from 'noncompliance' to 'reduced adherence', so prescribing communication skills to students can lead to a range of resistant behaviours such as simulation (pretending to do what one cannot do) and dissimulation (pretending to do the appropriate thing when one normally does something different). This can be seen as an iatrogenic effect of training, as a 'compulsory miseducation' (Goodman, 1964). These symptoms then infect the assessment process, where students can readily fake performances (Hodges, 2010).

Reinders, Blankenstein, and van Marwijk (2011) show that the reliability of consultation skills assessments in family practitioner training settings is better for real than standardized patients. Benbassat and Baumal (2009) suggest that typical OSCE-based assessment of communication within a clinical skills setting (using standardized patients) is both invalid and unreliable. The assessment may not measure student learning, but rather reflects a 'one-off' teacher judgment that goes against the spirit of the occasion—that students can and should learn communication as a product of reflecting on quality of *dialogue*. Benbassat and Baumal suggest a series of post-consultation debriefs in which students formatively learn about the strengths and weaknesses of their communication capabilities in conversation with expert tutors as a dialogue. This conversation should, of course, include the patient's feedback.

Summative feedback can naturally develop from a cycle of patient encounters and linked formative conversations with tutors and (actor) patients.

For all of its power in reporting and making sense of the research evidence in doctor–patient communication, Roter and Hall's (2006) seminal book-length review of the evidence base does not formally discuss competing theoretical frameworks that may inform such communication, although these are widely debated in psychiatry, psychotherapy, and clinical psychology education. One wonders just what influence psychiatry as a specialty has on medicine and medical education generally. Helpful frameworks developed within psychiatry include broad approaches such as psychodynamic, family therapy, cognitive behavioural, and humanistic existential. There are historical fluctuations in the fortunes of these approaches—for example, psychodynamic approaches were popular in the 1950s and 1960s, only to be eclipsed by humanistic, and then cognitive behavioural, approaches. This is partly based upon available evidence of the effectiveness of approaches, but is more open to political/economic/instrumental influences.

For example, a limited number of sessions of cognitive behavioural therapy (CBT) may show immediate, measurable results in patients, but this approach has been criticized for dealing with symptom rather than cause. Also, CBT is cheaper than longer term therapies, but does this treat the patient merely as a consumer in an economic transaction, putting 'retail' before 'therapy'? The lengthier 'educative' psychodynamic approaches set out to address cause rather than simply treat symptoms. CBT also deals just with the individual, rather than an individual in the context of a system, such as a family group, which systems therapies—such as family systems approaches—address.

Accounts of 'communication skills' training in medical education rarely refer to theoretical basis (or bias), which means that either theory has not been addressed at all, is assumed, or is subsumed within 'practical' concerns. It is difficult to know then how to judge outcomes research in this area because the overall 'outcomes' of major theoretical positions in communication education differ so widely. For example, a medical student in an assessed 'integrated' OSCE station takes a history from a patient and in another station, examines a patient. It is right that we should assess how well students communicate and how well they integrate the technical aspects with the nontechnical (e.g. palpating a patient while explaining clearly what is being done; taking—or, rather, receiving—a history asking an appropriate mix of open-ended and closed questions, rather than mainly closed questions).

However, a psychodynamically oriented approach would not just reduce the encounter to technical skills. There would be discussion about *style* and *demeanour*. Importantly, assessors would look for subtleties in the student's approach that included cognizance of the meaning of non-verbal cues and affect generally in the encounter; the meaning of what was unspoken or remained unresolved; and the *dynamics* of the encounter in terms of transference/countertransference and resistance/counter-resistance (did this patient remind me of someone I know well or someone I dislike; did an inappropriate degree of intimacy or distance emerge in the

encounter; did I stop myself from listening fully to what the patient said because he reminded me of someone I do not like, or I was repulsed by the patient; or did I listen closely because I was physically attracted to the patient, although I was perfectly aware of the dangers of this?).

Why do we suggest that a psychodynamic (or a broadly 'depth'-psychological) approach offers a potentially 'deeper' insight? For example, Roter and Hall (2006, pp. 73–74) summarize studies on how 'liking' and 'attractiveness' affect the doctor–patient relationship. These are intriguing—for example, doctors are both less likely to interrupt and more likely to ask open-ended questions that facilitate dialogue from a patient who was rated high on 'good' appearance. But this is left at the level of description or mild exploration and does not shift to the level of possible explanation. Such studies do not say why doctors have preferences in the first place. What is the 'good' appearance of the patient mobilizing in the doctor's psyche or the cultural psyche in which that doctor is embedded? Psychodynamics at least aims for explanation and provides a model of analysis of behaviour, as a basis to supervision. Depth psychologically oriented supervision is currently notable by its absence from the educational supervision/professional development agenda for doctors and related health professionals such as clinical psychologists.

Again, most medical students are not choosing to enter psychiatry as a specialty, but these communication issues within a psychodynamic model would not necessarily be addressed, or thought important, within either a cognitive behavioural or a humanistic model. However, without a theory of unconscious motive, how might we read a student's clever dissimulation in an OSCE with an actor-patient, where she or he does everything right 'for the camera', but has already achieved a reputation on ward attachments of being cynical and callous towards patients? More importantly, how can we now intervene positively to support and help this student?

We have already introduced the idea that poor, or instrumental, teaching of communication skills can have iatrogenic effects. Again, iatrogenesis is medicine-induced illness (Illich, 1975), where the intervention brings unwanted or unpredicted negative consequences. In the realm of the physical, these include medical/surgical errors, the side effects of pharmaceuticals and hospital-acquired infections. In the realm of the psychological, paternalism in medicine can, for example, produce either the passive, unquestioning response of patient dependency or the active response of resistance to, and noncompliance with, the doctor's wishes or prescriptions.

There are more subtle possible iatrogenic effects in medical education. Just as Illich (1975) points out how reliance on medical professionals can 'deskill' a community in losing confidence (and then skills) for self-help and self-medication, so as instrumental or functional training in communication skills, such as empathy, may deskill medical students who already have effective communication skills. This can happen where students become *self-conscious* (rather than *self-reflective*) about what was previously transferred from life experience to patient encounters.

All About Empathy

To move on to the primary focus of this chapter—empathy—we have, first, a fundamental epistemological concern: how can we 'teach' or 'learn' what has not yet been properly conceptualized or at least is open to contestation? For example, Marshall and Bleakley (2009) argue that 'empathy' is a modern, instrumental (mis) reading of what Homer referred to as 'pity'. The complex affective state that is pity for another has been reduced through successive mutations of the everyday usage of 'pity' and through the rise of instrumental descriptors, such as 'empathy', that have filled the gap that the degradation of 'pity', its gradual withdrawal to backstage, has generated.

Further, Arno Kumagai (2008, p. 657) suggests that it may be 'inappropriate—and perhaps presumptuous—for medical schools to "teach" students empathy'. Rather, medical educators have a 'responsibility to engage the students in learning activities which allow them to shape the empathy and idealism that they bring into the educational environment into powerful tools for healing'. But what are the optimum 'learning activities', and where might they best be located? As we have said, an increasingly popular learning activity is teaching empathy in 'safe' contexts such as the clinical skills laboratory setting, rather than focusing upon what Arthur Kleinman (1988, p. 206) describes as 'the messy, confusing, always special context of lived experience'—which could be a description of the medical student's everyday world and/or the clinical setting during work-based learning experiences.

If the undergraduate medicine curriculum is not limited to what happens in the context of the medical school, but has a symbiotic relationship with the lifeworld of the student (as a preparation for being a recognized professional in society), then encouraging students to reflect on their everyday communication is valid, for this lifeworld involves sickness, emotional turmoil, intensity of relationship, and death.

What is different about the professional relationship of doctor and patient to the lifeworld experience is a mixture of three elements: the necessary emotional insulation and management of the countertransference and counter-resistance dynamics, to set up and maintain appropriate distance between patient and practitioner; the employment of a moral imagination and responsibility as a person in a unique power relationship with another; and the ethical responsibility for confidentiality. These three requirements may make the qualitative nature of the *professional* relationship quite different from that of *personal* relationships in the lifeworld, as hinted at earlier. But we should also recognize that where doctors hold responsible positions as citizens, it is sometimes difficult to draw a strong line between private and public worlds and not only a moral responsibility, but also a moral imagination, permeates both.

For Kumagai (2008) and Kumagai, Murphy, and Ross (2009), where reflection is mobilized to educate empathy, this requires students to develop narrative capabilities—understanding patients' stories and retelling these stories to colleagues for further understanding. He describes a program developed at the University of Michigan Medical School in 2003 called 'the Family Centered Experience'. This is a real-time,

structured learning experience, involving home visits to create dialogue between new medical students and volunteer patients and their families. The project aims to educate for a humane approach to medicine.

The approach purposefully challenges students' preconceptions (there is, e.g. a healthy 'culture clash'), and they have the opportunity to process what they learn in the field in reflective, small group settings that are expertly facilitated. I did not include 'family centredness' in the list of patient-centred models in the previous chapter. My concern is that the nuclear family is compromised, or made complex, as it extends to more than one family group. In the Metropolitan West, half of marriages end in divorce or separation so that children may be caught between two settings, producing divided loyalties. It is not clear whether students, in the program that Kumagai describes, learn, for example, basic family systems therapy to give them a theoretical frame to better appreciate and understand 'family', 'extended family', 'dysfunctional family', and 'dual family' dynamics. Talk of the 'extended family' is also less common nowadays. Further, North Americans are used to calling 'community doctors' 'family physicians' without the need to articulate critically the meanings of both 'community' and 'family', where the terms are also metaphorical.

It is also not clear how these new students may gain a narrative intelligence, or a sensibility for stories, given that Kumagai stresses that one of the ways in which meaning is learned for doctors is through stories. Does a narrative intelligence simply emerge through repeated exposure to patients, or should it be cultivated through educational framing? For example, in parallel to these important contacts with community members, do medical students study the basics of rhetoric, genre, plot, and characterization? Do they learn ethics through narrative? In what sense does story educate for tolerance of ambiguity?

Kumagai (2008, p. 653–654) claims that education for empathy—defined as 'identification with another individual's suffering'—is at the centre of this narrative-based approach. This is 'fundamentally different' from approaches to learning biomedical sciences, where it is *transformative*: 'a shift in non-verbalized, habitual, taken-for-granted frames of reference towards a perspective that is more open, reflective, and capable of change'. 'Perspective taking' is, again, a descriptor that is increasingly gaining use as an alternative to 'empathy' (Stern, 2006a, 2006b).

If, as Kumagai suggests, empathy is grounded in sensitivity to stories, should medical educators then get to know the bigger stories that lead to 'empathy'—the historical trails? Can history teach us anything about teaching and learning 'communication skills', such as 'empathy', in medical education? Communication skills are usually considered ahistorically, as given (transparent and unproblematic) activities. In fact, we need only return to the first two great books in the Western canon—Homer's *Iliad* and *Odyssey*—to find rich, informing, premodern texts about what modernity calls 'communication skills' (Bleakley & Marshall, 2012; Marshall & Bleakley, 2009, 2011, 2013). In an exercise that reminds us of the value of the medical humanities to medical education (Bleakley, Marshall, & Brömer, 2006), we will ground the story of empathy in the bigger story of the origins of Western storytelling, in Homer's epics.

First, however, let us engage in some contemporary conceptual housekeeping—again, 'empathy' is a problematic term. As Veloski and Hojat (2006, pp. 119–120) warn, 'the theoretical investigation of physician empathy has been hampered by ambiguity in its conceptualization and definition', where 'there is no agreed-upon definition of the term'. Worse, empathy may be an operational term for a psychological state that 'may not even exist'. In other words, empathy could be treated as a metaphor. Indeed, a key text on empathy in medicine—*Empathy and the Practice of Medicine*: *Beyond Pills and the Scalpel* (Spiro, McCrea Curnen, Peschel, & St James, 1993)—is paradoxically replete with the authors' uses of *metaphors* to describe empathy in a collection that is otherwise characterized by the desire to represent empathy as an empirical phenomenon.

Metaphors of transportation, site, and resonance are common and commonly occur together, describing placing oneself in the lived experience of the patient's illness and entering the perceptual world of the other, as cognitive events of understanding and insight, rather than compassion. In a book-length (empathic) treatment of 'sympathy', Lauren Wispé (1991) discloses the core metaphor for empathy as that of travel or crossing over. This raises questions concerning the motives for that travel gleaned from anthropological study concerning the morbid curiosity of the tourist to the desire for conquest and control of the imperialist or colonist.

Such conceptual ambiguity places us in the same position as the circular operational definitions of ambiguous psychological notions such as 'intelligence'—that 'intelligence is what intelligence tests measure'. Empathy may be what empathy scales measure, or is a *construct*, a useful heuristic, rather than a tangible state of being. Yet, we undeniably feel moved in the presence of suffering, as witness to that suffering. And we can argue that 'witness to suffering' is a core identity construction of the doctor. As introduced earlier, a suitable descriptor for this feeling is 'pity', as described by Homer. Substituting pity for empathy is not merely a semantic sleight of hand.

The dictionary definitions of 'empathy' and 'pity' reinforce the argument that empathy is a modern, operational term, grounded in technical–rational thinking, whereas pity is an ancient term grounded in aesthetics. *The Shorter Oxford English Dictionary* defines empathy as: 'The power of projecting one's personality into, and so fully understanding, the object of contemplation'. In contrast, pity is defined as 'A feeling of tenderness aroused by the suffering or misfortune of another and prompting a desire for its relief'. The first definition implies mastery, the second, a contemplation and appropriate action, importantly qualified by the descriptor 'tenderness'. This is stereotypically a more 'feminine' response of *discrimination*—grounded in aesthetic, rather than instrumental, values.

You would think that the dictionary definition of pity is hard to beat, but the word has been corrupted in modern usage, as a kind of sneering. The novelist Graham Greene (1993) starkly captures this view: 'Pity is cruel. Pity destroys. Love isn't safe when pity's prowling round'. And Michael LaCombe (1993, p. 60), writing in the persona of a senior devil to a junior colleague, recommends using pity to pervert empathy: 'permit them to see their patients as simpering fools, helpless wrecks of humanity with whom they could never identify. Let this pity grow, spread like a cancer within them, and you need not worry'. Such understanding of pity is idiosyncratic. It requires a distancing from the object and a feeling of superiority that most

would not think was implicit in the term. We have indeed tipped over into instrumental empathy. Definitions matter. Or perhaps this is a matter of understanding and experience rather than definition.

The roots of empathy and compassion appear superficially similar: -pathy and -passion derive, one Greek, the other Latin, from words to do with suffering. Their difference lies in their prefixes—suffering 'in' ('em') or 'with' ('com'). In fact, the Latin word *patior*, from which 'passion' derives, had a meaning largely confined to suffering or tolerating unpleasant experiences, whereas *pathos* was a much more neutral word meaning experiences both good and bad. *Chambers Dictionary* subconsciously reflects this ambiguity by translating the '-pathy' of empathy as 'feeling' and of sympathy as 'suffering'. The word 'sympathy' existed in classical Greek times with a meaning very similar to today's usage, while empathy had different meanings, either a physical affliction (e.g. in Galen), or to mean a state of emotional engagement (the opposite of apathy). 'Pity' derives from the same word as 'piety', the Latin *pietas*. In Old and Middle English, the two senses were intermingled, only separating in the sixteenth century, when both words took on negative meanings—as a kind of knowing superiority.

Paradoxically, when empathy entered modernist thinking, it was wholly grounded in aesthetics, but has since lost this foothold. Although Jodi Halpern (2001) finds echoes of the term in Hippocrates, it is a twentieth-century invention, formally coined by the German psychologist Titchener in 1909 as a translation of the German *einfühlung*—literally meaning 'aesthetic sympathy'. Indeed, Titchener's description only provides further ambiguity, where he says of empathizing with another's expressions or qualities, such as pride, that he 'feels them in the mind's muscle' (in Wispé, 1991, p. 78). The metaphor is again one of movement, of crossing over, of a paradoxical 'at-a-distance' proprioception, but now we are in the body of the mind, an unfamiliar territory for contemporary cognitive models of empathy.

The German philosopher Theodor Lipps (1851–1914), who had a formative influence on Freud's model of the unconscious, used *einfühlung* as early as 1903, originally in aesthetics, to describe a process of the observer 'entering into' a work of art, and it is only later that such language was used by him to describe entering into the mind of a person. Importantly, in these early formulations, the passions are clearly engaged, and this differs greatly from contemporary definitions of empathy as the *cognitive* or knowing partner to affective 'compassion'. In conclusion, there is not only conceptual confusion concerning 'empathy', but the word carries an inherent paucity.

Communication, Virtue, and Virtuosity

Policy documents typically prescribe how doctors should behave and communicate as professionals and list the virtues that inform these behaviours. For example, the UK GMC's regularly updated *Good Medical Practice* (2006, p. 27) includes 'probity' (being honest and trustworthy) amongst its recommendations, suggesting that 'probity' and 'acting with integrity' are 'at the heart of medical professionalism'.

We should begin, then, as did the ancient Greeks, with such virtues. Discussions of virtue thread through Plato, particularly *Meno*, *Protagoras*, *Republic,* and *Laws. Meno* (Plato, 1956, p. 115), a dialogue between Socrates and a young aristocrat (Meno), opens with Meno's question to Socrates: 'is virtue something that can be taught? Or does it come by practice? Or is it neither teaching nor practice that gives it to a man but natural aptitude or something else?' Socrates' rhetorical strategy is to not answer the question, but to direct attention to the key prior question: what is virtue? In answer to this, Socrates says: 'The fact is that far from knowing whether it can be taught, I have no idea what virtue itself is'.

Over 2,400 years later, Louise Arnold and David Stern (2006, pp. 19–21) graphically model medical 'professionalism' as a classical Greek temple, where the supporting base (as three steps) is composed of 'clinical competence' (knowledge of medicine), 'communication skills', and 'ethical and legal understanding'. The roof is 'professionalism', and the pillars supporting the roof are four virtues: 'excellence', 'humanism', 'accountability', and 'altruism'. The authors explicitly equate professionalism with 'virtue'. 'Excellence', currently a buzzword in medical education policy documents, is characterized by 'a commitment to exceed ordinary standards'. Here, a return to classical Greece will help us to further define 'excellence' and also sharpen our understanding of 'virtue'. This, in turn, will lead to a better understanding and appreciation of 'empathy'.

In describing the relationship between rhetoric and athletics in ancient Greece, Debra Hawhee (2004, p. 17) describes a tradition of naming specific virtues, such as courage, but also of describing an overall 'virtuosity' (*aretē*). Hawhee describes Greek athletic competition as a form of 'rhetorical practice and pedagogy' in which competitors persuaded, or won over, the audience through their bodily prowess or virtuosity. In early Greek athletics, winners were judged by their ability to enter the field of play (*agōn*) as a warrior enters the battle, showing the virtues of courage, honourable engagement, and physical prowess. However, as athletic contests matured, virtuosity was judged as excellent where it explicitly avoided moralizing or piety. This subtle shift framed virtuosity as a highly focused or concentrated activity combining physical prowess (skill) with wisdom of the body (*mētis*) that is best translated as 'adaptability', expressing an art of timing or exploiting opportunity (*kairos*). This combination goes well beyond mere competence, turning sport into performance art. In the field of play that is the *agōn* of communication in medical practice, excellence might better be termed virtuosity, where virtuosity is a combination of skill (in reading, and responding to, cues), adaptability, and the art of timing.

Let us explore this a little further with emphasis upon empathy. While technical virtuosity—for example, as surgeon, diagnostician, or psychiatrist—is easy to grasp, how might we frame virtuosity in the nontechnical realms, such as communication and its subset of empathy? Arnold and Stern (2006, pp. 21–24) describe empathy as a subset of 'humanism'—one of their four pillars of virtue—along with respect, compassion, honour, and integrity. Further, these virtues must be enacted (or performed) for them to have any meaning, and this enactment is embodied in communication that is clinically informed and ethical. These authors distinguish

empathy from compassion, where empathy is defined as a cognitive 'ability to understand another person's perspectives, inner experiences, and feelings without intensive emotional involvement', plus 'the capacity to communicate that understanding'. Compassion, in contrast, refers to the affective dimension of being 'moved by the suffering or distress of another and by the desire to relieve it'. Where Homer describes what we might now call the skilful employment of empathy, he uses the term 'pity', which artfully collapses the modern technical (and arbitrary) distinction between cognitive and affective components.

The shift from the virtue of the communicator to virtuosity in communication serves an important function—it links us back to classical thought in two senses. First, in Homeric Greek language (and then thinking), there is no sense of personal agency as intention. Medical students come with the modernist cultural baggage of 'introspection', 'autonomy', and 'self-regulation'—descriptors that would have had no meaning in Homeric Greek. Modern 'empathy' is considered as something that comes from within oneself and is projected onto another, as the dictionary definition suggests. However, in Homeric Greek, there is no 'I' who is 'empathic'. Rather, pity is embodied in an action or is a verb. Ruth Padel (1992, 1995), in discussing images of suffering in ancient Greek literature, does what medical educators now encourage—she shows that a value or a virtue can only be understood in terms of a performance. It is not what the medical student thinks that matters, but how he or she acts.

In Homeric Greek, many verbs, often those describing what we would now say as what goes on in the 'head' (cognition) or 'heart' (feeling), do not exist in the active form. Rather, the closest to this is a 'middle voice' verb, which is 'very close to passive, what is done to you by an outside agent'. Not 'I am disappointed', but 'disappointment is upon me', and this is known in the form of the resultant activity—disappointment as consequent, or subsequent, performance. 'Wishing' and 'fearing', for example, do not exist in the active form. If empathy, recast as pity, is considered as a verb rather than a personality trait, it is enlightening to consider it in this middle voice because we can now see that the *origin of pity is in that which inspires pity*.

In other words, we can shift emphasis from describing empathy as a personal character trait to placing the importance in its source. In the context of patient-centredness, *the source of empathy is in patients we treat*. This unhooks us from 'character training' in medicine and undue reliance upon role modelling. Rather, we are now interested in how medical students act with patients. Returning to Homer makes us think of 'patient-centredness' as a *verb*. Patients educate us into empathy as a response to their conditions and self-presentations.

While we have warned against cultivation of personality type in favour of consistently observable activities of patient-centredness, a return to classical thought also helps us to reframe the virtuous personality in terms of professional identity. Let us return to the conceptual model of professionalism proposed by Arnold and Stern (2006, p. 22). As described above, a supporting pillar, or virtue, central to professional behaviour is humanism, which includes empathy and compassion. Humanism is defined as 'a sincere concern for and interest in humanity', without which how

could doctors treat a variety of patients with concern? We will not pursue here the difficulties presented by that weasel word 'sincere', connected as it is with probity or honesty. Rather, we are interested in the implications of 'humanism' and its relationship to identity.

Empathy has been both literalized and canonized particularly by Carl Rogers (1957) in the fields of humanistic psychology and person-centred psychotherapy. With little critical attention, Rogers' holy trinity of therapeutic skills—empathy, congruence (genuineness or probity), and unconditional positive regard—have been drummed into aspiring counsellors for over half a century. Training workshops focus on acquiring skills of attentive listening, discriminating between empathy, underplayed empathy, or sympathy ('would a cup of tea help?') and overplayed empathy, identification, or 'compathy' ('you know, I had the same thing happen to me a couple of years ago and …'). 'Compathy' is a neologism of the person-centred school. The end product of such training can be a caricature of the 'engaged professional', sitting attentively, nodding deliberately, and reflecting ('tell me more …'). A symptom of this approach, noted earlier in another context, is the index in Roter and Hall (2006) having six entries for 'nodding', but none for 'pity'. (There are 13 for 'empathy'.)

Now, as long as humanistic person-centredness is neither pious nor the exercise of political correctness, surely it offers a good model for patient-centred practice. Well, there are varieties of humanism and one can be humane without subscribing to modern humanism or personalism. Person-centredness readily aligns with narcissism—so characteristic of our age of celebrity status—that is a symptom to be cured and not a mode of curing. It is a short step from the inappropriate role modelling on celebrities, whether associated with eating disorders, body image, or being in recovery from multiple addictions, to the general health choices of impressionable adolescents. Cultivating the self is not necessarily a positive health choice—we have become extraordinarily sensitive to our inner psychological states, yet wholly insensitive to the quality of our environment (Hillman & Ventura, 1993). Egology has replaced ecology.

In an effort to provide an alternative to the humanistic tradition's way of thinking about 'selfhood' and identity, Michel Foucault (2005a, 2005b) made a close study of late Greek and early Roman texts that describe a 'care of the self'. These texts do not address a core self that must then realize its potential (the view of Carl Rogers and other humanistic psychologists), but show how an ethical self can be developed, constructed, or produced within a setting. In the same way that athletes can attain virtuosity through practice and artful engagement, so persons can shape themselves aesthetically, or 'form' character, *in contexts*. Such a background provides a new reading of medical education—not just as a technical training, but also as an aesthetic self-forming, to shape a professional identity. Hawhee (2004, p. 93) equates this process with *phusiopoiesis*. First described by the pre-Socratic philosopher Democritus, *phusiopoiesis* is the '*creation* of a person's nature' (our emphasis) grounded in poetics or aesthetics, not in instrumental 'skill'.

Groopman (2007), Stern (2006a, 2006b), and Ginsburg and Lingard (2006) offer comment on professionalism that critiques the current technical–rational discourse

constructing notions of 'empathy', while none of these authors mention *phusiopoiesis*, refer to Foucault's ground-breaking work on classical accounts of care of the self, or engage with the topic historically. As we have seen in a previous chapter, the seasoned American physician and practiced communicator (a staff writer at *The New Yorker*), Groopman (2007, p. 17) suggests that how a doctor thinks (clinical reasoning and diagnosis) 'can first be discerned by how he (*sic*) speaks and how he listens'. Communication and diagnostic acumen are closely related—better doctors discover from the patient through close attention and build a therapeutic relationship.

Groopman's elegant observation could be taken directly from one of the primers on self-fashioning that Foucault interrogates. Foucault (2005a, 2005b, pp. 98–99) discusses texts by Philo of Alexandria (20 BCE–50 CE) and Epictetus (c.55–135) that suggest those interested in care of the soul, as well as care of the body, could form a 'clinic' where you learn collectively how to do philosophy. We can readily translate this into contemporary medical education, where aspiring doctors learn both how to treat the body and how to set up the circumstances that will offer a healing or therapeutic *relationship* with patients. Importantly, at the same time, the medical student is doing work on identity or forming a style of life.

In Foucault's reading, Epictetus (Foucault, 2005a, 2005b, pp. 339–340) provides far more sophisticated advice on speaking and listening than most contemporary texts on the medical encounter. For example, Epictetus warns about being captivated by the speaker and not listening through to what is underneath the surface talk. This recognizes that talk is acting rhetorically and certain persuasive elements must be recognized and challenged. Listening is also charged rhetorically. We can listen in various ways—hearing what we want to hear (rhetorical listening), missing the point (not listening well), or listening well (offering benefit both to speaker and listener), including knowing when to be silent. Speaking and listening are not instrumental but an art, requiring discrimination and diligent practice.

This links us to Stern's (2006, p. 7) suggestion that communicating well can be seen in terms of 'connoisseurship' (a term borrowed from the educationalist Eliot Eisner), as 'the ability to make fine-grained discriminations amongst complex and subtle qualities' and to Ginsburg and Lingard's (2006) warning that communication within professionalism is not about what is a 'right' approach but what is *appropriate for context*. Again, judgment, or discrimination—an aesthetic quality—precedes the functional aspect of communicating (Bleakley, Marshall, & Brömer, 2006). Ginsburg and Lingard switch emphasis from the teaching and learning of communication skills, or a body of knowledge concerning professionalism, to what people actually do in practice, emphasizing prior appreciation of rhetoric (how communication is used deliberately or unconsciously to persuade) and reflection (how do I justify my actions in retrospect, and how will this prepare me for future activity?).

The latter resonates with Stern's (2006, p. 7) suggestion that while connoisseurship is the 'input' for professional relationship with patients, there must be an output, and this is 'critique' or 'public report'—a reflexive form of educational assessment and accountability. This can also be read as a form of monitory democracy (Keane, 2009)—a meta-democracy, appraisal, and quality assurance.

This leads us to suggest that structured reflection on real clinical encounters is a better way of learning communication than artificial (simulated) encounters in the skills laboratory or communication suite.

Finally, to reinforce the point about the difficulties of modern humanism's association with personalism and the cult of the individual, Fred Hafferty (2006, pp. 294–296) notes that 'altruism' is a term that seems to be disappearing as the new lexicon of 'professionalism' takes hold. This also returns us to virtues closely associated with pity—but, explicitly, not with piety (Bleakley, 1992)! Altruism is the opposite of egoism. Modern empathy does not require altruism—indeed, psychological introspection as a basis to cognitive empathy would seem to resist altruism by definition. However, pity and altruism are bedfellows.

In summary, 'empathy' has become part of the unexamined fabric of communication skills teaching, taken as transparent. Through a 'return to Homer', we have problematized the modern notion of 'empathy'—now a pervasive term in medical communication. By questioning what can be seen as a false division between the cognitive act of empathy and the affective state of compassion and by recovering a more poignant, ancient use of the now abused (and sometimes abusive) term 'pity', we have attempted to show how the Classics can enrich contemporary medicine, thus adding weight to the argument presented in Chap. 2 for the value of the medical humanities as core and integrated provision within medicine and surgery curricula. In this grounding in Classics, we follow Michel Foucault's impulse in his later work to map the future through classical, historical reference, articulating a history of the present.

In problematizing 'empathy', we have necessarily demanded complexity and ambiguity in an era where many medical educationists concerned with 'professionalism' have demanded simplification, clarity, instrumentalism, empiricism, and measure. We have called for a return of empathy to its aesthetic ground as a challenge to the reductionist approaches characterized by instrumentalism, where empathy can be read metaphorically rather than literally, and we applaud moves to characterize empathy as a form of connoisseurship.

Finally, we have argued for a reading of empathy as a verb rather than a noun, so that empathy is context-specific, as act or performance, rather than personality condition. However, doctors who distinguish themselves through the quality of their communication and 'fellow feeling' (Adler & Brett, 2009/1938) may be seen as cultivating a style of life or work, as an aesthetic self-forming, a shaping of identity. If the communication dimension to medicine—patient-centredness—is a kind of performance art, then it is better nourished by the deeper structure of pity than the surface operations of empathy. Scripts are also better learned in the real field of play (the *agōn*) than in rehearsal in the artificial communication suite. Empathy may be framed as an overall virtuosity (*aretē*), rather than a specific virtue or character trait, realized as a rhetorical activity.

'Empathy', returned to an aesthetic ground in 'pity', does and should defy definition. However, socialized within an empirical, scientific tradition, most medical students, educators, and researchers prefer clear concepts and well-defined boundaries. They will rejoice at the work of Hojat, Gonnella, and Mangione et al. (2002);

Hojat, Gonnella, and Nasca et al. (2002); and Hojat, Mangione, and Nasca et al. (2004) in utilizing a scale to measure empathy, which assumes that one first knows what is being measured. This reflects a modern mindset that tells us we understand by anatomizing, rationalizing, and articulating. It is an instrumental mindset that may, paradoxically, be the opposite of the empathic mindset that it both examines and teaches. Even if empathy could be taught, would it be fair to our students? Would not classes in narcissism and self-interest be of greater benefit? What if there has been no evolution, no progress in our moral sensitivity? That is why the stories of Greece and Rome resonate with us and can inform our ethical practice, while pity, sympathy, empathy, and compassion have been examined formally in medical education for only half a century (Wilmer, 1968).

Perhaps more complex than empathy is the issue of gender as a framework for discussing communication in medicine. I have already suggested that one of the structural, historical burdens for contemporary medicine to address is its (male) gender bias. Yet this bias is now colliding with an increasing majority of women entering medicine over men. It is this thorny issue that the following chapter addresses.