ABSTRACT. This essay will argue for the centrality of empathy in the doctor-patient relationship—as a core of ethically sound, responsible therapeutics. By “empathy,” I intend an explicitly hermeneutic practice, informed by a reflexive understanding of patient and self. After providing an overview of the history of the concept of empathy in clinical medicine, I discuss current definitions and the use of Balint groups in residency training as a way to develop empathic competence in novice physicians.

KEY WORDS: empathy, hermeneutics, Balint, interpretation, doctor-patient relationship, narrative, reflexivity

1. INTRODUCTION

More than a decade has passed since Jay Katz published *The Silent World of Doctor and Patient*, a groundbreaking study of the many obstacles to establishing mutually trusting, respectful relationships in medicine. The SUPPORT group’s recent report on hospital care for patients at the end of life reveals that pervasive miscommunication among health care professionals and patients continues to impede delivery of responsible, responsive care. One of the great strengths of Katz’s original study was his awareness that “unconscious and irrational determinants” inform the actions of both physicians and patients, undermining the possibility of mutual understanding, care, and respect.1

Empathy is central to establishing such mutually empowering therapeutic relationships. The following article discusses empathy as a form of clinical hermeneutics and describes the use of Balint groups to enhance residents’ facility for empathic interpretation of patient narratives. Maureen Milligan and I have argued elsewhere for the ethical necessity of empathic attunement in the doctor-patient relationship2. Let me begin by defining empathy and elaborating on our claim.

2. EMPATHY AND CLINICAL MEDICINE

Although the concept of empathy originally was coined in the 1870s as part of the psychology of esthetics, it was soon appropriated for the fields
of human psychology, Freudian psychiatry and, more recently, all clinical medicine. In popular parlance it is commonly—and mistakenly—defined as a synonym for sympathy, pity, or compassion. More recently, within the fields of critical social science, hermeneutics, and relational feminism, empathy is understood as a form of reflexive, interpersonal knowledge. Perhaps Roy Schafer’s definition best captures the resonant quality of empathic understanding in the doctor-patient relationship when he describes it as “the inner experience of sharing in and comprehending the momentary psychological state of another person.”

Over thirty years ago Robert Katz wrote of the importance of empathy as an underpinning to responsible patient care. Empathy establishes that “we are recognized and accepted for the particular kind of person we are . . . When empathy is lacking our self-awareness and self-respect are diminished. We then experience ourselves more as objects and less as persons.” Katz was primarily considering the patient, but the same can probably be said for the physician. After all, how can the physician or other health care worker empathize with the patient’s world, interests, values, and relevant past experience without a similarly well-developed insight into his/her own experience and values?

Empathy begins with an openness to the patient, the ability to see, hear, and understand—the patient and oneself. It has been defined variously as “knowing what another person is feeling,” and “feeling what another person is feeling.” Neither definition, however, captures the degree of self-awareness required for empathy. Nor do they acknowledge the limits of empathy. Empathic knowing yields a close approximation of the inner world of another person—but no more than that. As Lorraine Code has written, it is unconvincing to say “I know just how you feel.” Nevertheless, medicine’s goals of competent, compassionate, just and fitting patient care require that physicians develop the ability to be empathically attuned to their patients’ experience of illness. Iris Marion Young has written, “Justice begins in a hearing, in heeding a call, rather than in asserting and mastering a state of affairs.” That might well define the goals of medicine, too. It certainly points to the role of empathy in the accomplishment of those goals.

Empathy is sometimes described as the ability to imagine the other’s inner world. But this is only the beginning. To the extent that we can establish a coherent sense of another’s interior world, we must turn imagination back on itself, reflexively seeking the sources of our reconstruction of the patient’s world in our own past experiences. This hermeneutic process of reflexive interpretation involves a constant oscillation back and forth between observation of the patient, and of ourselves, allying