Empathetic Practice

The Struggle and Virtue of Empathizing with a Patient's Suffering

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Empathy is sometimes so hard to achieve that one may wonder if it is a virtue for caregivers at all. Perhaps a caregiver cannot always know how a patient feels, and perhaps that knowledge is sometimes too painful to possess. A nuanced understanding of what empathy entails and of the conditions for attaining it can help ground its possibility.

Dr. Sanchez walked into Marie's room. Marie was forty-five years old and recovering after a bone marrow transplant. Her post-transplant course had been particularly rocky. She had had multiple infections and been transferred to the intensive care unit three times in the past two weeks. She was beginning to lose hope that she would ever be able to get home to her family. As Dr. Sanchez approached, Marie's seven-year-old daughter, Vicky, who was hanging off her mom's bedrail, asked, "Mommy, when are you coming home?"

Dr. Sanchez took a heavy breath; Marie's despair echoed in her own chest. Dr. Sanchez crouched next to the bed, gently squeezed Marie's arm, and affirmed, "We're going to get through this together."

Tears filled Marie's eyes. She pulled Vicky close, forcing a snuggle. "Okay, if you say so," Marie responded. Vicky, seemingly unconcerned, twisted from her mom's grasp and somersaulted out of the bed in a squeal of laughter. Marie and Dr. Sanchez couldn't help but laugh along with her.

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Although nurse Joe Randall met Alex only last week, he had heard about him before. Few people with Duchenne muscular dystrophy live as long as Alex, who was twenty-nine; they usually die in their late teens or early twenties from cardiac or respiratory failure, the result of this progressive disease of the muscles. Joe knew Alex had a tracheostomy, which permanently attached him to a ventilator. Joe also remembered when Alex had received a heart transplant—his cardiac surgeon had seemed shocked things went so well. But none of that history mattered today. Wearing a mask, gloves, and a thick blue gown, Joe entered Alex's room to change his diarrhea-soaked bedsheets. Joe tried to relax his face

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and resist gagging against the waves of odor filling the room. Alex seemed unconcerned by the smell and continued playing Halo on his Xbox. Joe moved closer. "How are you, Alex?" Joe hated that question; it seemed empty, silly even. Anyway, it probably didn't matter. Alex huffed in response, hardly acknowledging Joe's existence, just as he hardly had all week.

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The case of Dr. Sanchez is a familiar story for clinicians. Acts of empathy, understood here as acts of understanding how another person feels, occur frequently in clinical practice. Regardless of the extent to which Dr. Sanchez affectively and cognitively grasps Marie's experience, most will agree that she is engaged in some level of empathy. It is because of cases like this that the import of empathy in clinical settings is widely acknowledged. In health care, empathic interactions are associated with beneficence, metrics of patient satisfaction with clinical encounters, bonds of trusting or caring, and emotional support and meaningfulness. This is why Dr. Sanchez's empathic attunement to her patient and her daughter is typically considered virtuous—that is, a character trait that caregivers should aim to possess.

However, cases like Joe's show both that the enactment of empathy is sometimes challenging and that it can be reasonable to wonder if empathy is a virtue at all. Perhaps Alex's suffering is simply too massive: Joe cannot possibly know how he feels, so why try? Perhaps empathy would only cause Joe to suffer along with Alex—can we morally obligate an activity that is so painful? As with many patients who suffer, Alex's experience of and response to usual attempts to understand and feel with him pose a challenge to typically empathic clinicians. Not only is empathy difficult to produce in the context of Alex's suffering; it may not even be possible; and if we simply cannot muster empathy, what is the point of morally demanding it?

Our analysis of empathy will hinge on the complexities of patients who are acutely suffering. We will investigate how empathy's phenomenological nebulousness in Joe's case generates doubts about its virtue. The fact that empathic endeavors fail or become substantially burdensome in cases like this, unlike in the case of Dr. Sanchez, calls into question empathy's general relevance as a virtue of clinical practice. In response, we will distinguish different kinds of empathic engagements from one another and offer separate counsel. We will argue that it is important to understand empathy as something that must be honed across varied contexts before it can be called a virtue. Conceptualizing and operationalizing empathy in this way will help to ground its possibility and virtue even in the most challenging and complex clinical encounters.

What Empathy Entails

The underlying phenomenology of empathy has a long history in Western philosophy. Its contemporary Western meaning was expressed best by David Hume, though he used the word "sympathy" to convey it: "No quality of human nature is more remarkable, both in itself and in its consequences, than that propensity we have to sympathize with others, and to receive by communication their inclinations and sentiments, however different from, or even contrary to, our own."[1]

The empathic connection shown in the case of Dr. Sanchez demonstrates Hume's point. In each empathic interaction, an empathic practitioner "feels with" another's experience and can arrive at some appreciation of how the other feels.[2] This understanding comes in degrees of both affective and cognitive uptake. Perhaps Dr. Sanchez senses Marie's agony (affectively) and grasps its cause (cognitively). she affectively resonates Marie's distress but does not fully understand its source. Regardless, Dr. Sanchez is trying to gain and likely achieves some understanding of how Marie feels.

Increasingly, empathy is seen as crucial to better and more effective patient care,[3] and so attention in clinically focused literature has shifted toward how empathy can be taught as a practical skill for clinicians.[4] Yet this same literature reveals disagreement and uncertainty around the very definition of empathy. This uncertainty may reflect the different paradigms that constitute the taxonomy of cases in which empathy arises. Mohammadreza Hojat and colleagues, for instance, claim that empathy is about perspective taking and that "the affective domain is a key component of sympathy, rather than empathy."[5] Others insist that empathy includes both affective and cognitive components but see it as distinctive from other emotional interactions.[6] For instance, empathy is often contrasted with sympathy, where the former is defined as feeling with another or knowing how another feels, and the latter is taken to mean feeling for—feeling badly for someone, for example. Still others conflate empathy with other emotional interactions.[7] This lack of consensus makes it challenging to identify what it means to be an empathic clinician. If we cannot identify instances of being empathic in clinical settings, how can we decipher its value in more nuanced contexts like the nurse's above?

Philosophy and the social sciences reflect a similar uncertainty about empathy's ontology; yet they also offer a degree of clarity. While some in these disciplines argue that empathy consists merely in cognitive perspective taking,[8] they largely agree that empathy is about understanding how others feel and that this understanding incorporates both cognitive and affective components that are distinct from other emotional responses like sympathy or compassion.[9]

On most accounts, empathy is about feeling *with* another and grasping the uniqueness of that experience.

One person might feel shame as the victim of bullying; another person, rage; and still another, indifference. It is for this reason that Hume's language "however different from, or even contrary to our own" is germane. So understood, empathy represents emotional connection but also contains—simultaneously—affective and cognitive features that are critical to understanding how others feel in their own shoes. Lorraine Code, reflecting on Simone de Beauvoir, emphasizes the combination of connection and strangeness involved in empathy:

> De Beauvoir writes: "It is only as something strange, forbidden, as something free, that the other is revealed as an other. And to love him genuinely is to love him in his otherness and in that freedom by which he escapes" (de Beauvoir 1962). Empathy at its best preserves yet seeks to know the "strangeness," respects the boundaries between self and other that the "forbiddenness" affirms, does not seek to assimilate or obliterate the "freedom." Its ambiguity is manifested in coming to terms simultaneously with the other's likeness to oneself, and her/his irreducible strangeness, otherness.[10]

Empathy lies somewhere in the interstices between vicarious feeling and distanced perspective taking. It is not satisfied by clinicians feeling merely as their patients feel, as this may be undifferentiated and thus blind to experiential uniqueness. Nor can empathy solely consist in the recognition of a patient's emotional state, as this may be too narrow and detached to allow for robust connection and understanding. Empathy requires perspective taking and imagination[11] but also relational engagement to ensure accurate attunement. It thus involves assimilating the affective elements of a patient's suffering and, simultaneously, recognizing and seeking to know the "strangeness" of that experience.

In the final analysis, despite disagreements over the specific mechanisms of empathy[12] and the content of empathy,[13] most agree that empathy refers to understanding how others feel, that this understanding takes emotion as its central object, and that it is oriented toward others' experiences rather than one's own. We take this broader ontology as a starting point so as to delve more deeply into empathy's practice and moral worth in the clinical setting. We contend that this feeling with, when trained and honed, can be excellently sensitive to nuances and even dramatic differences in patients' emotional experience; it demonstrates its worthwhileness in the form of respect and care for patients' emotional lives.

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Empathic Attunement: Value in Clinical Practice

Empathy has been heralded as a critical feature of both social and moral development[14] and moral action.[15] But it has also been flagged as prone to stereotype or bias,[16] overly burdensome,[17] unrealistic,[18] and unnecessary for moral action.[19]

These concerns become more palpable in the clinical setting. In cases like Joe's, clinicians might worry that empathy is impossible and that attempts at empathizing will lead to unwarranted distress and burnout.[20] In the context of immense suffering, the easy expressions of empathy taught in early medical or nursing school, such as asking, "How do you feel?" or offering a comforting touch, suddenly become superficial and even destructive to patient care.

This is made clear when we imagine what Joe's patient, Alex, might be thinking. One can imagine the nurse's story shifting perspective and revealing a patient who finds Joe's attempts to talk to him painful:

Alex was nearing the end of his life, and he knew it. Although most of his memories were cluttered up with visits to the hospital, this last week was worse than anything he could remember. His parents had driven him to the emergency room one week ago because of abdominal pain. He overheard one of the nurses in the emergency room say, "Twenty-nine-year-old male with Duchenne muscular dystrophy, here with epigastric pain and diarrhea. How is this guy still alive?!" before wheeling Alex off to X-ray. X-rays had shown a stool ball the size of a cantaloupe lodged in his descending colon, and he was admitted for a "clean-out." He would have laxatives pumped into his stomach through his feeding tube until the stool ball had been flushed out. Cramps ripped through his abdomen in violent waves. Diarrhea poured out into a giant diaper, overflowing the sides and soaking through his bedsheets. He had no control over his anal sphincter. He felt disgusting and humiliated. He tried to sleep, but the slamming doors and the incessant monitor beeping always jolted him back to reality. So he turned on his video games. But then he heard Joe's voice: "Hey, Alex, I'm so sorry that we're going to have to change you again. Can I help you roll over so we can get you cleaned up?"

Patients who suffer like Alex and live in worlds so different from common experience can cause clinicians

to question both the meaning and worthwhileness of empathy. On the one hand, a patient like Alex might reject empathic advances or recoil in response to a compassionate touch. How can Joe empathize if Alex consistently refuses to engage and even aggressively rejects his efforts to attune and understand? On the other hand, Alex's suffering is so vast that we may wonder if Joe can ever really know how Alex feels, even if Alex were to accept Joe's efforts to feel with him. In such cases, determining the nuances of empathy can be difficult, and it is understandable that many would avoid empathy or even reject empathy's clinical and moral import.

Empathy as a Practice

In less contentious contexts, medical practitioners and patients alike find happiness in the sense of living well and doing well in empathic engagement insofar as they feel emotionally connected, fulfilled, caring or cared for, and respected. And insofar as the empathic engagement is chosen, knowingly rehearsed and honed, and done for its own sake,[21] virtue is possible. But virtue cannot be fickle; empathy cannot be virtuous if it instantiates flourishing in some contexts but impedes flourishing in others. In addition, it cannot be both impossible and worthwhile at the same time. For these reasons, we must understand how empathy manifests what Aristotle called "*eudaemonia*"—that is, flourishing or living well—even more when it is questioned and contested than when it is immediately accepted as virtuous.

As a first step, it is important to distinguish empathy as a kind of clinical practice from the character trait of a particularly well-attuned practitioner. Compare it to the practice of listening to a patient's heart. A new student will quickly learn to use a stethoscope and thereby participate in the practice of cardiac examination. However, only a well-trained and skilled clinician will reliably sense the auditory and tactile nuances of mitral valve prolapse or diastolic heart failure, in so doing inhabiting a kind of excellence in clinical practice. Likewise, framing empathy as a kind of practice helps to distinguish superficial attempts to engage with another person empathically from the empathy enacted by someone who is well versed in its complexities. It is only the latter, understood here as empathic attunement, that holds the potential for virtue.

Empathy is a practice insofar as it constitutes a type of "cooperative activity . . . that not only aims at certain ends but creates certain ways of living and develops certain characteristics (virtues) in those who participate and try to achieve the standards of excellence peculiar to that practice."[22] Recent scholarship treats empathy as an individualistic phenomena insofar as it concentrates on empathy as a mental state or internal experience that might be cognitive or affective, accurate or inaccurate.[23] However, we offer a shift in perspective from the individual mental state to the relational engagement of empathy. Consistent with much of the literature in philosophy and psychology outlined above, empathy fits the mold of a practice because it requires receptivity, openness, and cooperative dialogue. Most importantly, empathic interactions are characterized by a distinctive end: knowing how another person feels. Take Alasdair MacIntyre's example of football, wherein the game of football counts as a practice but throwing a football skillfully does not.[24] Likewise, one might hone skills important to engaging in empathic practice, such as recognizing expressions of emotional distress or resonating another's deep sadness. But empathy is no mere skill or mental state. Rather, it is a myriad of ways in which one person can engage with another. It includes verbal and nonverbal communication, physical touch and sustained presence, and sometimes personal familiarity. In the clinical setting, empathic practice reveals itself in clinicians aiming to understand how their patients feel, orienting to their patients' distinctive emotions, and being receptive to those emotional states. Clinicians do this in cooperation with their patients, relying on their patients' openness, as when Marie allows Dr. Sanchez to take on some of her burden. And together, patient and clinician share the end of connecting through emotional understanding; as a clinician strives to understand how a patient feels, the patient seeks to be so understood.

A clinician may engage in empathic practices intermittently or unconsciously. The engagement may even be perfunctory, such as when a clinician asks a patient, "How do you feel?" while absorbed in a computer screen. Such interactions display superficial engagement in the practice of empathy, but they fail to manifest the durability and reliability of a character trait. This participation in the practice is not much different from absently and unskillfully tossing a football at a party while simultaneously engrossed in conversation. Only clinicians who have intentionally trained themselves in feeling with others over time, gained insight and sought experience relevant to understanding nuances in patients' perspectives, and honed this attunement across various contexts and with a diversity of patients will count as empathically attuned; that is, only such clinicians will have the *virtue* of empathic attunement.

Knowing the difference between empathic attunement and the myriad of activities and interactions that fall under the umbrella of the practice of empathy is critical to interpreting the value of empathy in Joe's case. Clinicians reasonably hesitate to empathize, even in trivial ways, with patients like Alex in part because it seems too superficial, in part because they know that Alex doesn't want to hear it, but also in part because they know that they can't really understand how he feels. Moreover, as Alex seeks pain relief through his video games, it can be difficult to read his face and

sense his feelings. Still, clinicians well practiced in empathy can overcome these obstacles and empathically attune themselves to a patient even under such challenging circumstances.

Those clinicians well versed in empathizing will seek moments in their engagement with Alex in which they have no further aim—not even the aim of effective clinical care. They may orient themselves to him in more nuanced ways than to other patients. For a patient like Alex, merely imagining how he feels will not suffice. Empathy may require sitting in the room with him, not facing or talking to him—simply waiting for him to engage while absorbing the uncomfortable silence that often follows this kind of practiced presence. It may mean being sarcastic and poking fun at his TV show choices or trying a hand at Halo. An empathically attuned clinician will orient to Alex with the understanding that it may not be possible to change his frustration. The idea is to spend time in different ways focusing on Alex and trying to decipher how he feels, since he is not apt to come right out and say it.

Moreover, empathic attunement means maintaining moments of self-other differentiation even if this distinction at times collapses. Clinicians might, for instance, be prone to think he is embarrassed by the smell in the room because they would be, but in fact, that might not be a central concern for him. So, while Alex's clinicians can allow for moments of resonating his feelings, when they walk into the room and immediately sense his anger or sadness as it washes over and through them, they will also have to be careful to pause to consider the differences, de Beauvoir's "strangeness," between how he feels and how they might feel in his shoes. Otherwise, they may damage the relationship by trying to engage in ways that he is unprepared for or unwilling to participate in.

Lastly, it will be important to remain sensitive to fluctuations in Alex's preferences, to know when he seeks engagement and when he feels the need for distance. To try to engage with Alex when he seeks space would be a failure of empathy, insofar as understanding how another person feels entails understanding the emotional need for distance just as much as the need for closeness. To know that Alex wants his clinicians to back off just is to know how Alex feels. This can be complicated by the fact that Alex may behave similarly when he needs space and when he needs close affiliation. To grapple with such nuances in Alex's emotional experience may require spending time with him even when he refuses to speak and even when he doesn't have specific medical needs to be met, or taking him outside for a walk, or teasing him about a love interest.

In the end, those who are well practiced in empathy will find that empathy happens fluidly and reliably most of the time. Still, empathically attuning to a patient like Alex does not invariably mean that an empathic clinician will be able to change his suffering in recognizable ways; Alex may never show a smile or say, "Thank you," let alone open up emotionally. Further, we can acknowledge that Alex's clinicians may never find complete knowledge in that empathic connection, as only Alex fully knows his own suffering. At the same time, empathically attuned clinicians will strive for empathic connection and appreciate its presence when it forms, whether in an impromptu hug or spontaneous laughter. And, as many clinicians will attest, we can recognize that those who are well trained can and do come to understand how Alex feels in robust ways even if the resulting knowledge inevitably feels incomplete.

The Virtue of Empathic Attunement

When we recognize the practice of empathy as nuanced and that empathic attunement requires training, knowledge, and deliberate effort, its virtue can be realized, perhaps especially in cases like Joe's. One might cognitively grasp that Alex is despondent, even ready to die. One might regularly take up his sadness upon seeing his face. One might come to understand his frustration as he vocalizes aggravation over another missed week of work or school. Ultimately, virtue is found not in the exact mirroring of Alex's emotional experience but in how the process of empathically attuning deepens relationships, recognizes and respects Alex's emotional experience, and offers knowledge. All of these are integral to caring for Alex's suffering.

Only clinicians who have trained themselves in feeling with others, gained insight and sought experience relevant to understanding nuances in patients' perspectives, and honed this attunement across various contexts and with a diversity of patients will count as empathically attuned.

Deepening relationships. People suffer when they both lose their sense of self and experience their life through a negative mood.[25] Empathic attunement responds to this suffering directly in two senses. First, people are relational: relationships matter to them, construct who they are, and partly constitute their flourishing.[26] In the wake of immense and chronic pain or otherwise debilitating disease, a patient can be prevented from building flourishing relationships with others. In Alex's case, he has

spent so much time in the hospital that he is prevented from regular engagement with peers. In addition, he faces daily norms that magnify his difference. This lack of ability to develop deep and meaningful relationships with others creates, intensifies, and perpetuates the experience of suffering. Nuanced efforts to be with Alex and to understand him respond precisely to this need.

It is because one can feel badly for or be concerned for another without developing a relationship with that person that the demonstration of empathic concern and other emotional responses like sympathy and compassion—which involve sensitivity to and concern for another's plight but do not involve feeling with—can reinforce distance between providers and patients. David Schwan argues that this is appropriate; he suggests that clinicians aim for *clinical empathy*, which he describes as "attention to emotion without sharing emotion,"[27] expressly because it is more cognitive and detached emotionally. Schwan argues that "people often feel sympathy without sharing any of the actual affective states of the target,"[28] but this misses the force of emotional connection in cases like Alex's. The more detached forms of empathic perspective taking will inevitably fall short of the care that Alex needs. In fact, he will likely reject such "empathic" demonstrations outright because they fail to reflect understanding of how he feels, maintain distance regardless of whether such distance is desired, and may be interpreted as patronizing insofar as they neglect the importance of recognizing and sharing in Alex's distinctive emotional knowledge.

However, empathic practice as we have interpreted it requires clinicians to dig in, remain curious, stay attentive, and be present while they attempt to gain a better understanding of a patient's emotional experience. It is much more like forming a friendship, which takes time, patience, and interpersonal knowledge. This means being with Alex to provide space for empathy and making oneself vulnerable to Alex's anger and sadness in ways that are similar to interactions with close friends. After all, to come to know how a patient feels, such that one is feeling with while at the same time respecting difference, is one way of developing a close connection with that patient mentally and physically.

Even if clinicians cannot know what it is like to be so close to death, they are at least likely to be responsive to aspects of his emotional experience as it shifts throughout the day and over time. The more they are with him, trying to understand his feelings bit by bit, the more likely they will be to understand the behaviors that suggest he needs space and the behaviors that suggest he needs a friend in the room. In these efforts, clinicians may find that they are able to deepen their relationships with Alex in a way that manifests flourishing. Even if there are not deep conversations, there may be moments of smirks, winks, vulnerable sighs, or quick tears of release that manifest the sort of connection of which patients like Alex are so often deprived. This empathic attunement can, in a more than modest way, ameliorate his suffering from loss of relationality.

Recognizing and respecting emotional experience. There is a second way in which empathic attunement offers moral value in contexts like Alex's. One who suffers experiences the world differently and may find it more difficult to be recognized or understood by others. This can deprive Alex of something common to our everyday lives: being known by others through emotional attunement. The immense pain, humiliating experiences, and debilitating difference that come with his suffering can make unfamiliar others turn away out of fear or can make him avoid others as a precaution. This creates and deepens the experience of suffering much as a lack of relationships does, but specifically with regard to understanding and respect. It is in the not being understood emotionally that, in part, Alex suffers. But in the face of this, efforts to understand how he feels that are appropriately sensitive to the "strangeness" of the experience can demonstrate immense respect for his emotional life.

Still, it may be that no matter how cautious about and responsive to Alex's moods clinicians are, no matter how much effort is put into developing a bond with him, no matter how deeply his clinicians strive to imagine what life is like for him, his suffering makes it impossible for them to fully understand how he feels or for him to accept the relationships and attempts at understanding that are offered. But when we think of empathic attunement as a virtue within the practice of empathy, we can differentiate the value of the process from that of the result. Much as playing in a soccer match can be worthwhile even if one's team doesn't win, engaging in an empathic process with another can be worthwhile even when one may not, in the final analysis, ever reach the deep empathic understanding that was hoped for. In Alex's case, the process of empathically attuning to him could still be critical to ensuring respectful care and nonabandonment. We think that empathic attunement is distinguished partly in that it offers affiliation and understanding even if it does not succeed. At the very least, this amounts to a kind of respect, in the sense of "giving appropriate consideration"[29] to someone's emotional experience. This is because clinicians' efforts demonstrate that Alex's feelings matter, that his perspective is privileged, and that his clinicians are there to be with him and help carry some of the weight even if they cannot understand it in any robust sense.

Thus, while it is possible that clinicians could develop a robust empathic attunement with Alex, there is value in empathically attuning even when full understanding is not reached. In maintaining openness to Alex's emotions, clinicians embody respect for those emotions and a pathway for deeper relationships and understanding. As Catriona Mackenzie recognizes, simply stepping back

and imagining how Alex feels will never be enough and may even be disrespectful of the uniqueness of his experience.[30] Instead, when clinicians stand by Alex even when they cannot feel what he feels, they demonstrate nonabandonment and affirm their respect for the knowledge he holds about his own experience.

Knowledge integral to care. Lastly, spending time with Alex in this way and striving to attune to his emotional state will provide knowledge about how to care for him. Knowledge about how a patient like Alex feels does not often count as medical knowledge in the modern "Baconian Project" of medicine,[31] which views health care as necessarily curative. Within that framework, it is typical for the more day-to-day health care work stereotypical of nursing, such as empathizing with a patient or caring for a wound, to be eclipsed by treatments considered curative (and therefore paradigmatic of medicine), such as a heart transplant or an orthopedic surgery.[32] And yet for patients with a life-limiting disease, there may be no curative therapies; rather, patients like Alex demand a more holistic conceptualization of medical care, treatment, and cure. While clinicians should continue to meticulously treat Alex's symptoms, they can also care for and tend to his suffering. Insofar as feeling with Alex over time provides knowledge of the particular ways in which he copes with anger and sadness, or in which he finds some joy, clinicians can use that knowledge to help alleviate his suffering even when they cannot directly treat or cure his underlying disease.[33]

In the end, these activities reveal a mode of caring that is distinctive of empathy and a manifestation of *eudaemonia*, to whatever extent any flourishing is possible in this setting. And it may be the only form of care and flourishing we have to offer. Being with Alex in his suffering and remaining open and willing to form an empathic relationship with him may be one of the more important instantiations of a caring clinician-patient relationship. Even without robust and accurate empathic knowledge, empathic attunement undoubtedly responds to Alex's need for relationships and understanding. Empathy offers care for his suffering when so many other methods have failed.

Flourishing in Relationships

Empathy beckons us to leave room, even in the challenging context of patient suffering, for appreciating emotional engagement in caring for patients. It teaches the value of a process of moving toward, rather than away from, emotional understanding with others. And even when the virtue of empathic attunement does not arrive at empathic knowledge, it moves us in the *direction* of this goodness. It is in this way much like other character traits that constitute virtue. For example, the path toward becoming a beneficent clinician is often riddled with missteps and misunderstandings, partial successes and effortful failures. One often engages in helping activities long before one acts beneficently or becomes a beneficent person. And even wholly beneficent clinicians will face significant obstacles to securing beneficence in some cases. Along these lines, Aristotle considers being virtuous a lifelong activity and declares that *eudaemonia* is not secured in a day but over a complete life.[34] In the end, expressing empathy skillfully, fluidly, and consistently serves both patients and clinicians.

Difficult cases call for pause because they are emotionally weighty, often leaving clinicians distraught and drained in ways that extend well beyond their clinical work. Clinicians face burnout particularly because of cases like Alex's, and they must balance cognitive distance and emotional engagement,[35] caring for others and caring for themselves. Even so, empathic attunement remains a viable and desirable option. Why, after all, should we assume that avoiding or removing emotional connections, focusing instead on something like distanced perspective taking,[36] is the best response to the burdens of emotionally understanding others? Indeed, a culture of emotional support and empathic understanding offers the best resolution to difficult cases. Shutting down emotions is not the appropriate solution to the emotional burdens of empathy. Cutting off empathic attunement and assuming clinical distance disables the very modes of care, respect, and connection that are critical to human flourishing and intrinsic to the practice of medicine as a moral art.[37]

The path toward becoming a beneficent clinician is often riddled with missteps and misunderstandings, partial successes and effortful failures.

Medical institutions should therefore focus on creating the necessary conditions for clinicians to practice empathy in the ways suggested above, permitting clinicians and patients alike to find greater flourishing in and through their relationships. As Richard Sobel recognizes, "There is no better antidote for burnout" than empathic and caring clinician-patient engagement.[38] Clinicians who suffer burnout may need the rejuvenation of connection similar to what suffering patients need. After all, when we encounter others while playing certain roles, we also encounter them as human beings, a form of encounter in which we are more similar than different. This common humanity is a bridge and leveler. Making sure that clinicians have the time and space to empathically attune to both their patients and each other, that they feel understood and supported by their

institution—these are the makings of care and relief of burden.

In the end, a more nuanced grasp of empathic attunement and the conditions that secure its actualization would require a fuller taxonomy and further differentiation of paradigmatic cases. Still, we can see the place of empathic attunement in flourishing clinician-patient relationships. In a virtue ethics framework, flourishing as a clinician will mean both being a good clinician and being a part of good clinical relationships. Empathic attunement offers a particular form of flourishing in relationship: both understanding the emotional lives of others and having one's emotional life understood by others.

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7. The Jefferson Scale of Physician Empathy, for instance, asks medical practitioners to rate the relevance of emotions in the clinical setting in broader regards, such as "I believe that emotion has no place in the treatment of medical illness" (Hojat, "The Jefferson Scale of Physician Empathy," S59).

8. W. Ickes, *Empathic Accuracy* (New York: Guilford Press, 1997).

9. See L. Code, *Rhetorical Spaces: Essays on Gendered Locations* (New York: Routledge, 1995); de Waal, *The Age of Empathy*; A. Coplan and P. Goldie, eds., *Empathy: Philosophical and Psychological Perspectives* (Oxford: Oxford University Press, 2014); M. L. Hoffman, *Empathy and Moral Development: Implications for Caring and Justice* (New York: Cambridge University Press, 2000); M. Scheler, *The Nature of Sympathy*, trans. P. Heath (London: Routledge and Kegan Paul, 1954); M. Slote, *From Enlightenment to Receptivity* (Oxford: Oxford University Press, 2013).

10. Code, *Rhetorical Spaces*, 141.

11. See R. Sobel, "Beyond Empathy," *Perspectives in Biology and Medicine* 51, no. 3 (2008): 471-78, at 474. A special thank you to a *Hastings Center Report* reviewer for alerting us to this insightful essay.

12. S. D. Hodges and D. M. Wegner, "Automatic and Controlled Empathy," in *Empathic Accuracy*, ed. W. Ickes (New York: Guildford Press, 1997), 311-39.

13. See W. Ickes, ed., *Empathic Accuracy*; Hoffman, *Empathy and Moral Development*; Singer and Lamm, "The Social Neuroscience of Empathy"; P. Goldie, "Anti-Empathy," in *Empathy: Philosophical and Psychological Perspectives*, ed A. Coplan and P. Goldie (New York: Oxford University Press, 2014), 302-17.

14. See de Waal, *Age of Empathy*, and M. L. Hoffman, "Empathy, Its Development, and Prosocial Implications," in *Nebraska Symposium on Motivation* (Lincoln, NE: University of Nebraska Press: 1977), 169-217.

15. See C. Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, MA: Harvard University Press, 1982); Hume, *Treatise of Human Nature*; A. Simmons, "In Defense of the Moral Significance of Empathy," *Ethical Theory and Moral Practice* 17 (2014): 97-111; Slote, *From Enlightenment to Receptivity*; A. Smith, *The Theory of Moral Sentiments*, ed. K. Haakonssen (1759; Cambridge: Cambridge University Press, 2002).

16. See K. L. Lewis and S. D. Hodges, "Empathy Is Not Always As Personal As You May Think: The Use of Stereotypes in Empathic Accuracy," in *Empathy: From Bench to Bedside*, ed. J. Decety (Cambridge, MA: Massachusetts Institute of Technology, 2012); J. Prinz, "Is Empathy Necessary for Morality?," in *Empathy: Philosophical and Psychological Perspectives*, ed A. Coplan and P. Goldie (New York: Oxford University Press, 2014), 211-29.

17. Gleichgerrcht and Decety, "The Costs of Empathy among Health Professionals."

18. See Goldie, "Anti-Empathy."

19. See H. D. Battaly, "Is Empathy a Virtue?," in *Empathy: Philosophical and Psychological Perspectives*, ed. A. Coplan and P. Goldie (New York: Oxford University Press, 2014), 277-301; Prinz, "Is Empathy Necessary for Morality?"

20. A. Back et al., "Why Are We Doing This? Clinician Helplessness in the Face of Suffering," *Journal of Palliative Medicine* 18, no. 1 (2015): 26-30.

21. *Nicomachean Ethics*, II.4; here and throughout, we reference the S. Broadie and C. Rowe translation of Aristotle's *Nicomachean Ethics* (New York: Oxford University Press, 2002).

22. C. Whitbeck, "A Different Reality: Feminist Ontology," in *Beyond Domination: New Perspectives on Women and Philosophy*, ed. C. Gould (Totowa, NJ: Rowman & Allanheld, 1989), 65.

23. See Ickes, *Empathic Accuracy;* D. Schwan, "Should Physicians Be Empathetic? Rethinking Clinical Empathy," *Theoretical Medicine and Bioethics* (2018): 1-14.

24. A. MacIntyre, *After Virtue* (Notre Dame, IN: University of Notre Dame Press, 2008), 187.

25. T. Tate and R. Pearlman, "What We Mean When We Talk about Suffering—and Why Eric Cassell Should Not Have the Last Word," *Perspectives in Biology and Medicine* 62, no. 1 (forthcoming, 2019): 95-110.

26. See, for example, C. Gould, *Rethinking Democracy: Freedom and Social Cooperation in Politics, Economy, and Society* (New York: Cambridge University Press, 1998); V. Held, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006); D. T. Meyers, ed., *Feminists Rethink the Self* (Boulder, CO: Westview Press, 1997).

27. Schwan, "Should Physicians Be Empathetic?," 8.

28. Ibid., 9.

29. S. L. Darwall, "Two Kinds of Respect," *Ethics* 88, no. 1 (1977): 36-49.

30. C. Mackenzie, "Imagining Other Lives," *Philosophical Papers* 35, no. 3 (2006): 293-325.

31. G. P. McKenny, *To Relieve the Human Condition* (Albany, NY: State University of New York Press, 1997), 2.

32. For more on the care versus cure dichotomy, see A. Mol, *The Logic of Care: Health and the Problem of Patient Choice* (New York: Routledge, 2008).

33. For a deeper examination of how empathic and holistic care can benefit patients and alleviate their suffering, see Tate and Pearlman, "What We Mean When We Talk about Suffering," 106-8.

34. *Nicomachean Ethics*, 1098a17-20.

35. See E. Gleichgerrcht and J. Decety, "Empathy in Clinical Practice: How Individual Dispositions, Gender, and Experience Moderate Empathic Concern, Burnout, and Emotional Distress in Physicians," *PLos ONE* 8, no. 4 (2013): e61526; Gleichgerrcht and Decety, "The Costs of Empathy among Health Professionals"; Halpern, "Clinical Empathy in Medical Care."

36. Schwan, "Should Physicians Be Empathetic?"

37. See S. Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame, IN: University of Notre Dame Press, 1986); A. Kleinman, *What Really Matters: Living a Moral Life amidst Uncertainty and Danger* (New York: Oxford University Press, 2006), 7; A. Kleinman, "Caregiving as Moral Experience," *Lancet* 380 (2012): 1550-1; A. Kleinman, "From Illness as Culture to Caregiving as Moral Experience," *New England Journal of Medicine* 368, no. 15 (2013): 1376-77; G. P. McKenny, *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany, NY: University of New York Press, 1997), 108-46.

38. Sobel, "Beyond Empathy," 478.