Alice and the caterpillar: Mining the meaning of 'empathy' in hospice and palliative care chaplaincy

At first glance, the title 'Alice and the caterpillar…' may seem a curious one for a Conference whose theme is: 'The Emerging Shape of Palliative Care Chaplaincy – Embracing the Challenges', so let me begin by explaining why I've used it. The first part of the title is, of course, a reference to Alice's conversation with Humpty Dumpty in Lewis Carroll's book, *Through the Looking Glass and What Alice Found There*.[1] If you know the book, it goes something like this – In the fantastical world on the other side of the looking glass, in which everything, including logic, is reversed, Alice and Humpty Dumpty are arguing over the meaning of the word 'glory'. Alice protests that she doesn't understand how Humpty Dumpty is using the word:

> Humpty Dumpty smiled contemptuously. 'Of course you don't — till I tell you. I meant "there's a nice knock-down argument for you!"'
> 'But "glory" doesn't mean "a nice knock-down argument",' Alice objected.
> 'When **I** use a word,' Humpty Dumpty said, in rather a scornful tone, 'it means just what I choose it to mean — neither more nor less.'
> 'The question is,' said Alice, 'whether you **can** make words mean so many different things.'
> 'The question is,' said Humpty Dumpty, 'which is to be master — that's all.'

In this paper, I want to explore what this might mean, using not 'glory' but 'empathy' as a paradigm and to question how a theological, chaplaincy-led critique, might shed new light on a concept which, though relatively new, has been subject to a range of interpretations, permutations and usages across the disciplines. It is a word that only appears, after all, at the turn of the of the twentieth century as an English translation of the German word, *Einfühlung*…

In the second part of the title, the caterpillar represents change. The caterpillar's life story – it's 'narrative', if you like (and we will be coming back to that word later …) is one of transition. It's form, and in some sense, therefore, it's identity, is marked by change, not perhaps by *re*volution, but, quite literally, by *e*volution, from egg to caterpillar, from caterpillar to pupa, from pupa to butterfly – For those of you with younger reading ages, I might equally well have referenced Eric Carle's wonderful children's book, *The Very Hungry Caterpillar*.[2]

Palliative Care and Hospice Chaplaincy, itself only emerging in the mid part of the twentieth century as part of a distinct discipline, like the word 'empathy', is not only something that can be understood – and *mis*-understood – in a variety of ways, but it is something that is also in transition, on a journey from where we began to where we will be. As your President, Karen Murphy notes in the recent book on *Chaplaincy in Hospice and Palliative Care*, which she

[1] Carroll, L. (1871) *Through the Looking Glass and What Alice Found There*. London: Macmillan.
[2] Carle, E. (1969) *The Very Hungry Caterpillar.* Hamish Hamilton.

edited with Bob Whorton, and to which I was delighted to contribute a chapter, '*the chaplain of today is very different from the traditional perceptions of a chaplain*.'[3]

In that same volume, Judy Davies, asks the question, '*what remains fundamental to the work of a chaplain?*' and her answer is significant:

> What matters is our capacity to listen, empathetically and without judgement, to the stories that people share with us; and, to do that, we need to be self-reflective, to engage with our own personal story and understand where it belongs in the broader narrative of our faith or philosophy.[4]

And living with this tension (positively understood…) between what remains the same – that ability '*to see the view through patients' eyes and to work within the landscape of the spiritual need of the individual*'[5] - and what, of necessity changes – for while not all change in progress, there can be no progress without change - is the theme of this Conference.

In this paper, then, we will seek to bring those two horizons – that of the multi-form concept of 'empathy' and that of palliative care and hospice chaplaincy as a changing service, or profession but with constant core values, into creative dialogue, and just as in the 'looking glass' world in which Alice finds herself, we may well be surprised by what we discover.

Where, then, do we begin? Writing in the Journal*, Annals of Internal Medicine*, Howard Spiro wrote that,

> empathy is the "almost magical" emotion that persons or objects arouse in us as projections of our feelings. Empathy requires passion, more so than does equanimity, so long cherished by physicians. Medical students lose some of their empathy as they learn science and detachment, and hospital residents lose the remainder in the weariness of overwork and in the isolation of the intensive care units that modern hospitals have become. Conversations about experiences, discussions of patients and their human stories, more leisure and unstructured contemplation of the humanities help physicians to cherish empathy and to retain their passion. Physicians need rhetoric as much as knowledge, and they need stories as much as journals if they are to be more empathetic than computers.[6]

Though there is neither the time nor the space to address the last point here, as part of a wider project of the Ethics of Artificial Inteligence (AI) this is a subject that I will be addressing elsewhere.

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[3] Murphy, K. and Whorton, B. (eds) (2017) *Chaplaincy in Hospice and Palliative Care.* London: Jessica Kingsley, p.11.
[4] Ibid., p.29.
[5] Ibid., p.30.
[6] Spiro, H (1992) 'What is empathy and can it be taught?', *Annals of Internal Medicine.* Vol. 60:653-670 (Volume publication date 10 January 2009) First published online as a Review in Advance on September 15, 2009.

Building on work that he had done in an earlier book, *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*[7] , Spiro makes some interesting observations here – first, that over the course of a century, empathy has acquired '*almost magical*' status. Second, his assertion that, '*Medical students lose some of their empathy as they learn science and detachmen*t', a statement that is borne out by recent empirical research, and, third, that '*physicians need rhetoric as much as knowledge, and they need stories as much as journals if they are to be more empathetic than computers*' has underpinned many of the developments of medical, nursing, other healthcare and, even, chaplaincy, education over recent decades, not least through the rise of the medical humanities.

So, what do we mean by 'empathy' and, indeed, can it be taught? In her recently published book, *Empathy: A History*, Susan Lanzoni traces the emergence of 'empathy' as a concept in English to a translation, though perhaps a rather crude and imprecise one, of the German word, *Einfühlung*, a word that has layers of, often nuanced, meaning.[8] The word is first recorded in English in the *Philosophical Review* in 1895[9] where, originally, the term was used in the world of art and aesthetics – one sought 'empathy' with an object, whether a painting or a piece of sculpture, or even an aspect of the natural world, in order to discern its meaning through a reaching-out beyond the self. This is why empathy, in whatever context, has frequently been related to the body and to bodily response and, a little later, I want to talk about the growing body of literature on the neural corrolates of empathy, not least in the work of neuro-psychologists like Simon Baron-Cohen.[10]

Since 2015, The Nuffield Department of Primary Health Sciences, in the University of Oxford has run what it calls the 'Oxford Empathy Programme', doing research and training on the evidence-based benefits of empathy in healthcare.[11] On their website they note this:

> Empathy is a term which has proven difficult for academics to define to their satisfaction. Yet doctors, patients, and lay people do not seem to have any trouble understanding what they mean by empathy. The extent to which empathy is a communication skill, an inner experience of the counselor, or the client's perception is also controversial.
> What remains uncontroversial in the literature we are aware of is that patient experience and patient outcomes seem to improve when they interact with 'empathetic' practitioners…[12]

Studies have shown that as a component of the relationship between the patient and healthcare professionals, empathy can have a direct impact on both diagnosis and patient care. Patients who feel listened to are more likely to fully explain their symptoms and to

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[7] Spiro, Howard M., *et. al*. (1996) *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel.* Yale University Press.

[8] Lanzoni, S. (2018) *Empathy: A History*. Yale University Press, p.ix. It was first used in a summary by E L Hinman of a paper by Kurd Lasswitz, a Kantian philosopher and science fiction writer.

[9] Jeffrey Aronson, 'When I use a word . . . A word about empathy.' BMJ Blog October 14, 2016. Accessed 05.05.19.

[10] Baron-Cohen, S. (2011) *Zero Degrees of Empathy.* London: Penguin.

[11] https://www.phc.ox.ac.uk/research/oxford-empathy-programme accessed 04.05.19.

[12] Ibid.

provide details pertinent to their care. Emotional as well as intellectual engagement may help doctors and other healthcare profession address aspects of a patients' health that might otherwise have gone unnoticed. Empathy in the clinical setting may also significantly influence patient satisfaction, lead to a better adherence to treatment recommendations, and reduce medical-legal risk.[13]

Nonetheless, the question is whether empathy is in danger of becoming '*a 21st century medical fashion'*[14] which, despite the number of papers on it, still lacks a sufficiently rigorous grounding in informed praxis – an area in which I will argue that the palliative and hospice chaplains in particular have much to contribute to the wider field of healthcare practice, whether through education, research, supervision or modelling.

It is certainly true that the work of people like Rita Charon – an American physician with doctorates in both Medicine and English, and another American physician, Arthur Frank, have done much to challenge the technological hegemony of modern medicine and medical education and the dominance of the biomedical model, with its focus on symptomology, by drawing us back to an understanding, and practice, of medicine, in all its forms, as a humane art in which empathy is championed as central to understanding the stories of illness that patients tell.[15]

Two of the outstanding patient exponents of the need for empathetic care who have shared their own narratives of life-limiting and life-threatening illness are an English academic, the social philosopher Havi Carel, who writes in her autobiographical book, *Illness*: '*If I had to pick a human emotion in greatest shortage, it would be empathy…*'[16], adding that whilst, '(t)*here are many terrible things about illness; the lack of empathy hurts the most.*'[17] Reflecting on her encounter with a spectacularly un-empathetic physical therapist, Carel wonders what sort of training had made her able, '*to stand there saying nothings, offering no word of comfort or distraction*.'[18] As a philosopher, her belief is that it is phenomenology's emphasis on first-hand experience[19] that offers a way of bridging the existential gap, to bring tangible benefits to care-receivers and care-givers alike, creating relationships of the kind of which the theologian Martin Buber speaks in his book, *I and Thou* in which, '*the parallel lines of relation meet*.'[20] In the face of medical and healthcare relationships which are often at best asymmetric and at worst non-existent, time and again, we hear patients (sic) asking, '*why am I not treated as a person, only as a case to be recorded or a disease to be managed…?*' Engaging with people as equals, however, requires demonstrating not just compassion but a fundamental human empathy.

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[13] Kathy A Stepien, Amy Baernstein 'Educating for Empathy', *Journal of General Internal Medicine.* 2006: 21: 524-530

[14] Jeffrey Aronson, 'When I use a word . . . A word about empathy.' BMJ Blog October 14, 2016. Accessed 05.05.19.

[15] Lanzoni, S. (2018) *Empathy: A History*. Yale University Press, p.6.

[16] Carel, H., (2013) *Illness.* Durham: Acumen, p.46.

[17] Ibid.

[18] Ibid., p.47.

[19] Cf. Merleau-Ponty – *'life is not what I think but what I live through…'*

[20] Buber, M. (1971) *I and Thou*. p.26.

The other author of recent note is the neuro-surgeon, Paul Kalanithi, who was diagnosed with terminal cancer and whose astonishing, deeply moving, and ultimately posthumous, account of his illness and approaching death is published in his book, *When Breath Becomes Air*.[21] As both a medical scientist and a practicing Christian, Kalanithi writes:

> Science may provide the most useful way to organise empirical, reproducible data, but its power to do so is predicated on its inability to grasp the most central aspects of human life: hope, fear, love, hate, beauty, envy, honor, weakness, striving, suffering, virtue.[22]

He concludes that, '(*b)etween these core passions and scientific theory, there will always be a gap*'[23], because, he says, '*Human knowledge is never contained in one person. It grows from the relationships we create between each other and the world, and still it is never complete*.'[24]

In such first hand narratives of the experience of illness and suffering we hear again and again the clarion call for an approach to medicine and healthcare that is fundamentally, intentionally and authentically *relational* and which therefore undergirds the essential process of meaning-making[25] in the face of a medical and healthcare culture that has slowly, almost imperceptibly, been transformed over recent decades from a profession into a service industry.[26]

Just note how the '*Hello, my name is…*' initiative in the NHS, as an attempt to redress this shift, is all about fostering relationship. It is, in itself, a 'mini-narrative' – it offers some appropriate self-disclosure, without imposition, and it invites a correlative response, without demand. Through its offer and invitation it sets the scene for, and enables, relationship.

The role and meaning of the care-giver/care-receiver relationship, has come under increasing scrutiny and re-valuation in recent years as we have increasingly recognised that focussing solely on the technical aspects of medicine, necessary though they are, is detrimental to medicine's broader objectives, since such an approach is fundamentally reductionist and atomistic – in other words, it places the focus on the disease and not on the person. Empathy, on the other hand, is fundamentally relational and therefore a holistic counter-balance to the atomistic lens, which fails to see that 'relationship' is essential to forming and maintaining the identity of the person who has such relations or relationships.[27] Interestingly, feminist advocates of care ethics, such as Nell Noddings are clear that 'caring' is grounded in our capacity to 'feel'/have 'feelings' and therefore to be able to think and act empathically.[28]

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[21] Kalanithi, P. (2016) *When Breath Becomes Air*. London: The Bodley Head. Cf. Nuland, S. (1995) *How We Die: Reflections on Life's Final Chapter*. Vintage Books.
[22] Ibid., p.170.
[23] Ibid.
[24] Ibid., p.172.
[25] It was Viktor Frankl who, through his experience as a survivor of the Holocaust, asserted that suffering could be reduced by enhancing meaning making.
[26] O'Mahoney, S. (2016) *The Way We Die Now.* London: Head of Zeus, p. 270.
[27] Cf. Slote, M. (2007) *The Ethics of Care and Empathy*. London: Routledge, p.74. See also McFadyen, A. (1990) *The Call to Personhood*. Cambridge: CUP and his notion of personhood as 'sedimented' through our network of relationships.
[28] Cited in Slote, p. 104 *et seq.*

From this presence, expressed through our own willingness to be in relationship with others in the I-Thou relationship characterised by Martin Buber, 'real' life, that allows for the continuity of the sense of self, emerges.[29] What is being offered, the context for this, is primarily a theology of presence – being (with) rather than doing, which constitutes what Neil Pembroke has described as '*a gift of the self*'.[30] This cannot be achieved without the willingness to be 'fully present' to the other, a precondition of which is empathy.

It is important, nonetheless, not simply to put these two elements in juxtaposition to each other, as if one were 'right' and the other 'wrong'. On the contrary, what we are describing here is rather the tension between **goals** and **values**, with the recognition of the place that each of these holds for those in hospice/palliative care, dependent upon their role and context. So, for the patient/care receiver – 'providing for the family' may be the 'goal', underpinned by the 'value' of 'working hard', whilst for the clinician - 'curing' patients may be the 'goal', underpinned by the 'value' of 'caring' or 'compassion'. Whatever our perspective, whilst our **goals** in life may change (previous goals may be, or become, unattainable), our **values**, by and large, remain, constant. Simon Robinson is correct when he notes that, '*Life meaning is attached to value…, meaning…is central to the life project and reflects the value of the person and her identity.'*[31]

This confluence of goals and values is often described in terms of healthcare 'competencies', which have been defined as '*the complex synthesis of knowledge, skills, values, behaviours and attributes that enable individual professionals to work safely, effectively and legally within their particular scope of practice*.'[32] It is this that allows practitioners to move beyond the personal to the interpersonal. The NICE document, *Improving Supportive and Palliative Care for Adults with Cancer,* describes this as '*the process of information exchange among patients, carers and health and social care professionals underpinned and enhanced by mutual understanding, respect and awareness of individuals' roles and functions, and is a process through which patients and carers are helped to explore issues and arrive at decisions.'*[33] We will return to the notion of empathy as a 'moral tool' later in this paper.

At this point, however, we ought just to pause a while and outline some of the fundamental differences between the related but different terms, *sympathy*, *empathy* and *compassion* – (The philosopher in me always needs to define my terms and, more often than not, that is as effectively done by saying what something is ***not***, as by saying what it is…)
First, there is **sympathy**. The root of the English word 'sympathy' lies in the two Greek words *sym* = 'with' and *patheia* = 'feeling'. It means feeling **<u>for</u>** what another person is experiencing,

[29] Buber, M. (1971) cited by Jonathan Pye in Murphy, K. and Whorton, B. (eds) (2017) *Chaplaincy in Hospice and Palliative Care.* London: Jessica Kingsley, p.85.
[30] Pembroke, N. (2002) *The Art of Listening.* Cambridge: Eerdmans, p.13 cited by Jonathan Pye in Murphy, K. and Whorton, B. (eds) (2017) *Chaplaincy in Hospice and Palliative Care.* London: Jessica Kingsley, p.85.
[31] Robinson, S., Kendrick, K., Brown, A. (2003) *Spirituality and the Practice of Healthcare.* Palgrave: Macmillan, p.32.
[32] Gordon, T., Kelly, E., Mitchell, D. (2011) *Spiritual Care for Healthcare Professionals: Reflecting on Clinical Practice*. London: Radcliffe, p.44.
[33] National Institute for Clinical Excellence, (2004) *Improving Supportive and Palliative Care for Adults with Cancer. Manual.* National Institute for Clinical Excellence.

without, however, necessarily entering into the experience and the feelings associated with it. In other words, there is an existential 'distance' that goes with sympathy.

Then there is **compassion**. Etymologically, its linguistic roots are the same as sympathy but via Latin rather than Greek – *com* = with, *pascere* = to suffer or to feel. Nonetheless, they are not the same. Even such an august source as the Oxford English Dictionary, in describing 'compassion' as '*sympathetic pity and concern for the sufferings and misfortunes of others*', proves itself inadequate since it tells us only half the story. Compassion is not only about 'pity' or 'concern' but how one acts *in response to* that which is experienced by another. As a relational construct, then, it takes us a step, but only a step, closer to defining 'empathy'.

Empathy, while it derives from the same *patheia*/*pasco* root (those of us who have recently celebrated Easter will have used that root word in 'paschal'…), rather than using the prefix 'with' (*sym* or *com*), uses the word, *em* = in; in other words, empathy is ***to enter into*** the feelings or suffering of another. Empathy carries with it, therefore, a spatial dimension – the ability to dwell in another's place and to see from this vantage point.[34] In contrast to the objective 'distance' of sympathy or, though less so, compassion – the feeling **for** what another person is going through, empathy posits a subjectivity, or even inter-subjectivity, so that the empathic person enters ***into*** a relationship with the sufferer that enables them to feel or suffer **with** the other, without being subsumed by them (and that is important). From a theological perspective, because it is about the 'entering into' of experience, 'empathy' has both incarnational and soteriological dimensions, which I think can be discerned in the writings of theologians like Martin Buber in *I and Thou,* and Paul Tillich[35], to name but two.

Now, of course, etymology, fascinating as it is, can only take us so far and usage - how the language, and what the language describes, is deployed is far more nuanced. But therein lies the problem, because 'sympathy' (and its corrolate, 'compassion') and 'empathy' are too often treated as synonyms – as though they can be used interchangeably.[36] So, for example, when Paul Kalinithi, reflecting on his own early medical practice says, '*I was not yet **with** patients in their pivotal moments, I was merely **at** those pivotal moments*.'[37] he is clearly describing empathy's difference, and a still developing empathic relationship. At this stage he had not yet learned to make the transition that Ros Taylor describes when she says, '*Numerous definitions try to capture the essence of palliative care, but for me it is about helping people navigate suffering and uncertainty. It is about **relationship**, not **intervention***.' (my stress)[38] Later, however, Kalanithi can write about his encounter with a patient that, '*I had met her in a space where she was a person, instead of a problem to be solved...*'[39] That's empathy!

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[34] Lanzoni, S. *Empathy*, p.6.

[35] Cited in Gordon, T., Kelly, E., Mitchell, D. (2011) *Spiritual Care for Healthcare Professionals: Reflecting on Clinical Practice*. London: Radcliffe, p.13. cf. Tillich's emphasis on the human condition's deep longing for being '*whole, not yet split, not disrupted, not disintegrated, and therefore healthy and sane*'.

[36] In the eighteenth century, 'sympathy' was the moral an aesthetic concept debated by the philosophers David Hume, Adam Smith and Edmund Burke and so before the inception of the word 'empathy' in the late 19th- early 20th centuries was, in fact, its corrolate.

[37] Kalanithi, P. (2016) *When Breath Becomes Air*. London: The Bodley Head, p.81.

[38] Taylor, R. 'Relationship Not Intervention' in Goodhead, A. and Hartley, N. (2018) *Spirituality in Hospice Care*. London: Jessica Kingsley, p.58.

[39] Kalanithi, p.90.

[During the workshops over the next couple of days I hope to be able to show a short, two minute, RSA video clip by Dr Brené Brown that demonstrates beautifully and clearly the difference between sympathy and empathy and to explore this further.[40]]

So, having said what it is *not*, what ***is*** empathy?

At one end of the spectrum, there are those who argue that 'empathy' is essentially something that is 'hard-wired' into us (a bit like Thomas Aquinas' understanding of 'Natural Law'). Empathy is, in other words, primarily biological and evolutionary.[41] It remains contentious, nonetheless, whether there is what has been called an 'empathy gene'. While cautious about this term, since genes '*cannot code for a high level construct like empathy*'[42] Oxford neuro-psychologist Simon Baron-Cohen argues that there are at least four genes that may be associated with it although he discounts the view that empathy is a kind of a binary operation (off or on), like a light bulb in the head. In reality, he argues, empathy is more like a dimmer control than an all-or-none switch.[43] He describes from his own research, not least into psychopathy, a 'bell curve' of empathy in which people range from 'zero degrees of empathy' (the title of one of his books), to high functions of empathy, with most of the population being more or less empathetic, depending on where they fall within the curve. As a psychologist, Baron-Cohen offers the following as a definition of empathy: '*Empathy is our ability to identify what someone else is thinking or feeling, and to respond to their thoughts and feelings with an appropriate emotion*.'[44]

[I want, at this stage, just to speak briefly about the role of what are called mirror neurons. Although mirror neurons were only first described in 1996, by the early 2000s they were being described as the key neural mechanisms for things like empathy and social understanding even though there remains little agreement about the 'contours' of empathy itself.[45] In short, mirror neurons are those neurons which 'fire' when we 'identify' with another person's situation and a bodily response is evoked in us - think, for example of watching a sporting event and feeling our bodies lean as the racing driver enters the bend, or our bodies 'lift' as the high jumper arches their body over the bar… (It is interesting that a piece of research determined that people who had had botox treatment, functioned significantly less well in empathy tests (being shown pictures of people expressing various emotions) precisely because they lacked the ability to 'mirror' the emotions presented to them.
Penny Wilcock, a hospice chaplain is absolutely right when she says that, '*to understand is not to replicate another's experience – that cannot be done – but to learn another's language, both phraseology and gesture, and to reply in kind*.'[46]

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[40] I am grateful to Clinical Psychologist, Naomi Pye, for drawing my attention to this clip.
[41] Cited in Baron-Cohen, S. (2011) *Zero Degrees od Empathy.* London: Penguin, p.100. Indeed, there are some, like Emory University primatologist Frans de Waal, who argue that humans are not the only species to be capable of empathy, though he acknowledges that in humans it may have evolved to a higher level than that seen other species.
[42] Baron-Cohen, S., p.89.
[43] Ibid., p.14.
[44] Ibid., p,12.
[45] Lanzoni, S., *Empathy*, p.251/2.
[46] Wilcock, P. (1996) *Spiritual Care of Dying and Bereaved People.* London: SPCK, p.47. She is also absolutely correct in her assertion that, '*…empathy has also to be balanced with the ability to keep a core of detachment*

In theological terms, we might describe such a bodily or 'embodied' response as 'incarnational'. Rowan Williams, for example, talks about the way in which '*theology is the art of tracing how God transforms the flesh by creating living relationships with God, and through that living relationship with the rest of what God has made*.'[47] Similarly, Jurgen Moltmann writes of '*the eternal love that feels with us and suffers with us.*'[48] If this is all about *who we are* not *what we do* – i.e. it privileges *ontology* over *function*, then, theologically speaking, we might even go so far as to describe empathy as a form of *imitatio Christi*. Karen Murphy, I think, hints at this when she says, '*…ultimately the uniqueness of chaplaincy lies in the way we use the only tool we have – ourselves.'*[49]

Whatever its biological drivers, then, empathy, therefore, begins with an initial, and imaginative, listening to oneself in order to leave behind what we ourselves might feel or think and move into what the other might be feeling or thinking.[50] But such perspective-taking begins, nonetheless, with the self-awareness without which other-awareness is not possible. It is what Scheler describes as '*a genuine reaching out and entry into the other person and his individual situation, a true and authentic transcendence of one's self*'.[51] To quote Susan Lanzoni, '*Empathy dares us to move beyond the habitual borders of the self to reach towards another human being*…'.[52] The theologian, Mary Grey similarly talks about, a '*spirituality of epiphanies of connectedness' a way of healing fragmentation and brokenness*…'[53]

In his recent book, *The Shattering of Loneliness*, Erik Vaarden begins by recounting how as a nine or ten year old child, living in Southern Norway, he had seen a farmworker at work, his back criss-crossed with scars. His father tells him that the man had been whipped in German captivity during the war, submitted to savage torture… Vaarden say, '*The image of the scars… was etched on my mind. It was as if the world's pain had entered, by them, into my protected universe, which remained disrupted. I felt vulnerable of a sudden, and exposed.*'[54]

As the moral philosopher, Michael Slote, puts it, *'…empathy involves having feelings of another (involuntarily) aroused in ourselves, as when we see another person in pain. It is as if their pain invades us*… '[55] And Slote is clear that in care ethic's need to account for our obligation to respect – and not just care for - others, because this is a fundamentally

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at the centre. One has to be always the listener, the observer; there has to be a certain coldness, a disunion, in order for empathy to happen; otherwise one will simply paint one's own values over the canvas of the other's life, obscuring the other's reality with one's own.' (46)

[47] Williams, R. in Baxter, J. (ed) (2007) *Wounds that Heal: Theology, Imagination and Health.* London: SPCK, p.5.

[48] Moltmann, J. (1996) *The Coming of God: Christian Eschatology.* London: SCM, p.126.

[49] Murphy and Whorton (ed), p.96.

[50] Cf Jacobs, M. (1985) *Swift To Hear.* London: SPCK, p.34. This is part of our developmental process as humans as the developing child learns to distinguish between, 'I' and 'not I', i.e. the 'other'.

[51] Cited in Robinson, S., Kendrick, K., Brown, A. (2003) *Spirituality and the Practice of Healthcare.* Palgrave: Macmillan, p.35.

[52] Lanzoni, S., *Empathy*, p.280.

[53] Grey, M. (1997) *Prophecy and Mysticism: The Heart of the Postmodern Church*. Edinburgh: T&T Clark, p. 20 cited in Baxter, J. (ed) (2007) *Wounds that Heal: Theology, Imagination and Health.* London: SPCK, p.16.

[54] Vaarden, E. (2018) *The Shattering of Loneliness: On Christian Remembrance.* Bloomsbury: Continuum, p.1.

[55] Slote, M. (2007) *The Ethics of Care and Empathy*. London: Routledge, p.13.

relational task, notions of empathy are key, offering '*a plausible criterion of moral obligation*.'[56]

There appears, then, to be two stages in empathy - **recognition** and **response** (and it may well be that it is the latter that distinguishes sympathy from empathy – but this is something we shall explore in the workshops later in the week). If this is the case, then empathy therefore requires not only the ability accurately to *identify* another person's feelings and thoughts, but the ability to *respond* to such feelings or thoughts with an appropriate emotion too. And it is when that happens that people begin to feel valued because they are being recognised as persons, and not just as a 'case'. In the study by Shane Sinclair *et.al*.[57] there was clear resistance in patient responses to sympathy, which most participants described as '*an unwanted and misguided pity-based response that was easily given and seemed to focus more on alleviating the observer's distress toward patient suffering, rather than the distress of the patient*.'[58] Patients had, however, a much more positive response to empathy. They described empathy as '*a more emotionally engaged process, whereby individuals attempted to attune to the emotions of the patient through acknowledgment of suffering*.'[59] Patients therefore experienced this as a genuine attempt both to understand and to engage with their emotional state.

One of the co-authors of that paper was Harvey Chochinov, a Canadian psychiatrist, who spent years researching the concept of dignity. He established that one of the key determinants of dignity is '*to feel that you are seen as you would like to be seen*' – which, while he does not name it as such, is one of the definitions and correlates of empathy.[60]

Of course, the ability to 'imagine yourself from another person's vantage point' requires a well-developed sense of self-awareness. In my experience of working in both fields, of theological education and medical education, I find this to be more evident in pastoral and practical theology and education than in medical education and training. It's interesting, isn't it, how though we speak of medical and theological *education*, we talk about *training* doctors or clergy. I always used to argue that in theological colleges we based what we did on the three principles of education, training and formation, whilst in medical schools the latter element was, and largely remains, conspicuously absent… That is perhaps why the evidence points to an overall reduction, rather than a growth, in empathy as students progress through medical school – because '*(m)edical education is still almost exclusively focussed on diagnosis and treatment, and not on 'outcomes' – the results of treatment*.'[61]
But it is empathy that makes the other person feel valued because they can see that not only their 'condition' but their thoughts and their feelings, the totality of that which makes them a 'person' have been heard, acknowledged and respected.

[56] Ibid., pp.6 and 16.
[57] Sinclair, S., Beamer, K., Hack, T.F., McClement, S., Bouchal, S.R., Chochinov, H.M. and Hagen, N.A. Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences *Palliative Medicine* 2017, Vol. 31(5) 437–44
[58] Ibid., 440.
[59] Ibid., 443.
[60] Cited in Goodhead, A. and Hartley, N. (2018) *Spirituality in Hospice Care*. London: Jessica Kingsley, p.66.
[61] O'Mahoney, S. (2016) *the way we die now.* London: Head of Zeus, p.134.

That leads us on to the question of whether empathy, whether or not it has a biological basis (and I think that in evolutionary terms I'm clear that is has… 'though, like much else it has a nature: nurture element to it), is something that can be taught and learned – can we, in other words, 'develop' empathy? The question might be akin to the question, 'Are good teachers *born* or *made*?' – Though we may well have forgotten much of the 'what' that we were taught at school or university, what remains with us is the feeling of the teacher who, in whatever way, inspired us with an interest in their subject. Many people, intellectually informed in their subject area, while they can be taught how to construct lesson plans and to set objectives and to deliver in the classroom, nonetheless may never be a 'true' teacher… can the same be said of empathy? Is it something for which we can teach 'technique' but for some will always remain elusive?

Medical and other healthcare educators have an interest in promoting empathy. For example, The Association of American Medical Colleges states in their Learning Objectives for Medical School Education: '*physicians must be compassionate and empathetic in caring for patients*.' (though, as in so many definitions, they fail to suggest how this is to be achieved).

In a meta-analysis of peer reviewed papers by Kathy Stepien and Amy Baernstein[62], their study indicate that empathy may, in fact, be amenable to positive change with a range of interventional strategies, with communication skill workshops addressing the behavioural dimension of empathy showing greatest qualitative impact on participants.

Applying it in the clinical context Stepien and Baernstein expand the vernacular definition of empathy as understanding or appreciating how someone else feels, to include emotive, moral, cognitive, and behavioural dimensions, which they define as follows (although the multidimensional nature of clinical empathy makes them difficult to measure):

- emotive, the ability to imagine patients' emotions and perspectives
- moral, the physician's internal motivation to empathize
- cognitive, the intellectual ability to identify and understand patients' emotions and perspectives
- behavioural, the ability to convey understanding of those emotions and perspectives back to the patient.[63]

Of these, I would argue that the first (emotive) is something which, to a greater or lesser degree, you have or haven't got – though we may help people develop techniques for accessing this; the second (moral) is contentious – and there are those who would challenge empathy's role in moral decision making[64]; the third (cognitive) probably lends itself most easily to the educative process, while the fourth (behavioural) is the outcome of the first three (and, again, skills can be inculcated – and it is here that evidence shows that training in communication skills is probably at its most effective…).

[62] Kathy A Stepien, Amy Baernstein 'Educating for Empathy', *Journal of General Internal Medicine.* 2006: 21: 524-530

[63] Ibid., 524.

[64] For an exploration of this, see: Slote, M. (2007) *The Ethics of Care and Empathy.* London: Routledge

It is at this point that I want to return to the question of 'narrative', although I don't intend to spend too much time on it here as I have written on this extensively elsewhere.[65] Whilst there are some who are deeply suspicious of the concept of 'narrative medicine'[66,67] there can be no doubt of its influence in the rise of the medical humanities.

Seamus O'Mahoney, in an otherwise excellent book, is one of those who is deeply critical of, and deeply sceptical about, narrative medicine – at least, as a 'movement'. He scathingly writes that:

> Although it is easy and amusing to poke fun at narrative medicine for its smugness, its pretention, and its risible jargon, there is a more serious issue at stake. Narrative medicine is spiritually arrogant and potentially harmful. It encourages doctors to stray from their core professional duties into uncharted waters, to take on roles such as spiritual adviser, social worker, life-coach, friend. Vulnerable patients may develop unrealistic expectations of doctors, hopes that will inevitably be disappointed.[68]

Nonetheless, he is clear that medicine is in a poor place, for he says, '*Medicine, for all its success, has become unsure of itself, particularly in the area of doctor-patient relationships*.'[69] and that, '*Evangelical atheism has accelerated the flight from religion, leaving us more adrift, more atomised, and unsure of how to behave when faced with the great events of our lives*.'[70] And these are areas that he sees as needing to be addressed.

There is no doubt, however that, '*meeting service users' actual…needs rather than their assumed needs means paying due respect and attention to their particular story, told their way*.'[71] Enabling the telling of stories and listening attentively to the ensuing narrative, and developing the skills needed to listen to the narrative effectively would seem essential since, as Arthur Frank, one of the key exponents of narrative medicine, observes, '*Through their stories, the ill create empathic bonds between themselves and their listeners*.'[72]

What, then, might fill the void? If Narrative Medicine is the reaction to the unrealistic expectations that scientific medicine has placed on those engaged in the practice of medicine and wider healthcare, that 'distances' the healthcare professional from the care receiver or service user, perhaps as O'Mahoney suggests, the pendulum has swung too far the other way,

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[65] Seem for example, Pye, J., Sedgwick, P., Todd, A. (eds) (2015) *Critical Care: Delivering Spiritual Care in Healthcare Contexts.* London: Jessica Kingsley, and Pye, J. 'Towards a Theology of Hospice and Palliative Care', in Murphy, K. and Whorton, B. (eds) (2017) *Chaplaincy in Hospice and Palliative Care.* London: Jessica Kingsley.
[66] O'Mahoney, S. (2016) *the way we die now.* London: Head of Zeus.
[67] O'Mahony, S. 'Against Narrative Medicine' *Perspectives in Biology and Medicine* Vol. 56, No. 4, Autumn 2013, pp. 611-619.
[68] O'Mahony, S. 'Against Narrative Medicine' *Perspectives in Biology and Medicine* Vol. 56, No. 4, Autumn 2013, pp. 611-619.
[69] Ibid.
[70] O'Mahoney, *The Way We Die Now* pp.54-5.
[71] Gordon, T., Kelly, E., Mitchell, D. (2011) *Spiritual Care for Healthcare Professionals: Reflecting on Clinical Practice*. London: Radcliffe, p.79.
[72] Frank, A. W. (1995) The Wounded Storyteller: Body, Illness and Ethics. Chicago University Press, p.xii.

and so empathy might hold out to us the possibility of a reasonable and practicable middle-ground: the 'synthesis' to the 'thesis' of scientific medicine and the 'antithesis' of narrative medicine.

In the end, as Paul Kalanithi, observes, '*openness to human relationality does not mean revealing grand truths from the apse; it means meeting patients where they are, in the narthex or nave, and bringing them as far as you can*.'[73]

And who might there be better placed to do this than the hospice or palliative care chaplain, whose role so often is to stand astride disciplines and so to act as the bridge between the medical and the spiritual, the doctor and the patient, the temporal and the eternal.

I said earlier in this paper that '*I always used to argue that in theological colleges we based what we did on the three principles of education, training and formation, whilst in medical education the latter element was conspicuously absent…*' In his commentary on the practice of empathy, Howard Spiro, with whom we began, concludes that, '*It really doesn't matter whether empathy is a thought or an emotion. Retaining or enhancing it in medical caregivers is worth doing. In this protocol-based era, selecting medical students as much for their character as their knowledge may be one way to promote empathy…*'

That phrase, '*selecting medical students as much for their character as their knowledge*' lies at the heart of what I see to be the relevance of this paper to the theme of this Conference. Having established, by hard work and determination, our place at the table, so to speak, we can offer a unique dual perspective, offering insights from our theological starting place, as well as into the place we occupy in the world of healthcare – not least, that good practice depends as much, if not more, on the rediscovery of 'virtue' as it does on skill or technical proficiency alone. Listening to the voices of those who suffer is one of our most difficult duties as human beings, but I believe it is a moral duty to do so, and thus empathy is not just a skill to be developed but an expression of what it is for us to be moral beings.

In the book, *Critical Care: Delivering Spiritual Care in Healthcare Contexts*, I note how the philosopher Simone Weil wrote that, '*the capacity to give one's attention to a sufferer is a rare and difficult thing*'. Whilst '*warmth of heart, impulsiveness and pity are not enough*' she argues that such neighbour-love (*agape*) means being able to say to him or her, '*What are you going through?*'. This 'extreme attention' (as Weil calls it) to others is the essence of other-orientation and, Weil argues, taken to its highest degree, is the same thing as prayer.[74] It would certainly seem to be a stunning definition of the power and cost of empathy.

Now that, as chaplains, we have established first, our identity and, second, our 'seat at the table', although in some context there may still be some way to go, the next step in the 'emerging shape of palliative care chaplaincy' may therefore lie, at least in part, in the possibility of deeper, more intentional involvement in the world of formal healthcare education, offering our unique insights into a pluriform and multi-disciplinary context. It might involve us in the selection, initial training and ongoing education of a whole range of

[73] Kalanithi, p.96.

[74] Jonathan Pye in Pye, J., Sedgwick, P., Todd, A. (eds) (2015) *Critical Care: Delivering Spiritual Care in Healthcare Contexts.* London: Jessica Kingsley, p.15.

healthcare professionals as well as contributing with increasing confidence to the work of policy-making, at all levels.[75]

I began by quoting the work of Howard Shapiro, speaking albeit about, and to, medical professionals, so let me end by citing him once more:

> Empathy is the foundation of patient care, and it should frame the skills of the profession. It may be that empathy can be taught by example, but the minds of students, like soil, must be prepared before they can nourish seeds of knowledge, and (he concludes) in some soils little grows.[76]

At least, that is, for now….

Rev Dr Jonathan H. Pye MA **May 2019**

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[75] Teaching in the Medical School at the University of Leeds, I and my colleagues developed elective modules on spirituality and medicine - work that is still ongoing, with medical students attending seminars organised through, and delivered in, the Chaplaincy drawing on the insights of chaplains, academics, care receivers and the students themselves. This built on work that I had begun at Bristol Childrens' hospital in the 1980s, which included workshops on empathy for doctors in practice).

[76] Shapiro, H. Commentary: *The Practice of Empathy*.