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## Empathy and Affect: what can empathied bodies do?

George Marshall Dr.

*The University of Notre Dame Australia*, [george.marshall@nd.edu.au](mailto:george.marshall@nd.edu.au)

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## **TITLE PAGE**

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### **Corresponding Author**

Dr George Robert Ellison Marshall

School of Medicine Sydney  
University of Notre Dame Australia  
Darlinghurst NSW 2010  
AUSTRALIA

Mobile +61405001907  
Telephone +61290874600  
Fax +61290874611  
Email [empathynode@gmail.com](mailto:empathynode@gmail.com)

### **Authors**

George Robert Ellison Marshall  
School of Medicine Sydney, University of Notre Dame Australia, Darlinghurst, NSW  
2010, Australia

Claire Hooker  
Centre for Values, Ethics and Law in Medicine, University of Sydney, K25, Sydney,  
NSW 2006, Australia

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# EMPATHY AND AFFECT: WHAT CAN EMPATHIED BODIES DO?

George Marshall and Claire Hooker

## Abstract

While there has been much interest in the apparent benefits of empathy in improving outcomes of medical care, there is continuing concern over the philosophical nature of empathy. We suggest that part of the difficulty in coming-to-terms with empathy is due to the modernist dichotomies that have structured Western medical discourse, such that doctor and patient, knower and known, cognitive and emotional, subject and object, are situated in oppositional terms, with the result that such accounts cannot coherently encompass an emotional doctor, or a patient as knower, or empathy as other than a possession or a trait. This paper explores what, by contrast, a radical critique of the Cartesian worldview, in the form of a Deleuzian theoretical framework, would open up in new perspectives on empathy. We extend the framework of emotional geography to ask *what happens* when people are *affected* by empathy. We suggest that doctors and patients might be more productively understood as embodied subjects that are *configured in their capacities* by how they are affected by singular 'events' of empathy. We sketch out how the Deleuzian framework would make sense of these contention and identify some possible implications for medical education and practice.

## Introduction

Empathy is widely acknowledged to be of great importance to the practice of medicine. It is considered to be an intrinsic good in itself – something that patients crave, a crucial responsiveness to the existential and psychosocial aspects of illness<sup>1</sup>- which, for many patients, may be the most significant features of illness<sup>2</sup>. Empathy is also considered to confer numerous instrumental benefits in medical practice. It facilitates doctor-patient communication and enhances mutual trust, producing a positive self-reinforcing cycle that can improve shared decision making, alert physicians to physical and psychosocial factors that affect diagnosis and treatment decisions, and help patients to comply with treatment regimens and develop positive health practices<sup>3 4</sup>. Empathy is good for doctors as well as patients. It can help avoid unpleasant or hostile interactions with patients and it confers significant satisfaction in relation to therapeutic goals<sup>5</sup>.

There is substantial evidence, indeed, that empathy may produce positive therapeutic effects directly, and not merely by its facilitation of good communication and hence more effective medical care. Empathy has long been considered a key component of treatment in many psychotherapeutic traditions<sup>6 7</sup>. There is now extensive evidence about how significant positive human relationships are for all aspects of good health: such evidence has emerged, for example, in studies of child development, social determinants of health, neuroscience, and clinical care<sup>7</sup>; empathy is part, and possibly the key to, this strong association. There is certainly evidence that empathy produces therapeutic 'context' (aka 'placebo') effects, often very powerful ones. That is, empathy can directly produce therapeutic benefit. In some cases these effects have

observable physiological mechanisms and correlates<sup>7</sup>. For example, there is recent evidence that empathic doctoring influences various physiological markers in patients with type II diabetes<sup>8</sup>.

However, the importance of empathy in medicine and health care is at present matched by a very extensive scholarly literature on empathy in health and medicine (and beyond), that upon inspection proves to be philosophically vexed, internally contradictory, and subject to significant critique over the past decade<sup>4-9-11</sup>. Its vexations have been comprehensively examined elsewhere; here we are most concerned with the question of how empathy can be defined (if at all), and by corollary, whether empathy is either truly possible or desirable.

To summarise a large literature briefly: for most (though not all) scholars, empathy is something more than simply feeling ‘sorry for’ a patient; it is considered to be about ‘understanding’ that patient’s unique experience. But what that understanding consists of – literal neuronal replication or ‘mirroring’<sup>12</sup>? ‘emotional resonance’<sup>13</sup>? – and how we come by it has been at issue. Can one person (the doctor) ever ‘feel with’ or directly ‘share’ the subjective experience of the patient, as suggested by some of the more dominant formulations of empathy<sup>11</sup>? Or is one limited to listening and observing and imagining, in part from analogies and models, the qualities of another’s experience<sup>14</sup>? These questions are of some moment for doctors, who wish neither to project their own assumptions onto their patients’ experiences, nor to get the information wrong, and hence make an incorrect judgment about diagnosis or treatment. As a result, some accounts see empathy as a predominantly or solely cognitive response, while others view it as intrinsically emotional. Similarly some insist that empathy is distinctive because it grants direct access to another’s experience (and hence, may be measured for its accuracy), while others argue that it necessarily involves imagination and analysis.

This paper seeks to address the problems with empathy ‘in theory’ by foregrounding the affective reality of medical consultations. Using insights from affect theory and some of the more recent developments in the understanding of human subjectivity in the work of Gilles Deleuze and Felix Guattari we approach the problem of empathy from a different place; one intentionally situated in the affective reality of consultation. Such a stance allows us to move beyond the pre-given or *ideal* forms of doctor and patient that can be seen to overly define the possibilities of what happens in medical encounters. In doing so we hope to suggest a different theory of empathy that will allow more practically useful definitions of empathy to emerge and thus enable further research into improving health encounters.

### **Empathy and the problems of modernity**

Following Reidar Pedersen, Rebecca Garden and others, we argue that an underlying and problematic discursive structure unifies these apparently disparate and oppositional accounts: they are all structured by the polarized dichotomies between subject and object, knower and known, mind and body, active and passive, science and society, culture and nature, (and masculine and feminine) that underpin modernity<sup>4-7</sup>. Thus all these accounts reproduce the ideals of objectivity and neutrality in medicine, such that the subjectivity of the *doctor*, who is supposed to be both

objective and neutral, is constantly elided, while the subjectivity of the patient is brought into view<sup>14</sup>. Similarly all these accounts construct empathic knowing as oppositional to, and hence needing to be kept in check by, the technical knowledge of medicine. In this way what empathy allows a doctor to understand is never anything about disease itself, or the patient's physical functioning; empathy is directed towards understanding the psychosocial and emotional elements of patient experience (which may impinge on treatment success, and so are worth attention). Our accounts of empathy construct cognition and emotion as distinct polar opposites; while empathy allows the latter a place in medical practice, it constrains that place so that it does not disrupt the ideals of objectivity, disembodied knowing and neutrality.

If, then we find that medical students and young doctors regularly lose empathy, we should not be surprised. It is because the sort of empathy they can have is of the constrained kind that occurs in a discourse in which technical knowledge and affective care are constructed as opposites and where being emotional, and having subjectivity (and a body) requires taking a subject position antithetical to that which defines the doctor. Or to say it in plainer language: so long as medicine is so fundamentally conceived around these dichotomies, only a weak and incoherent form of empathy will be available to us. The fact that empathy can (apparently) produce physiological change – something utterly inexplicable in the terms of current literature on empathy – is a practical demonstration of how both false and limiting these dichotomies are.

We would like to comment here on four additional issues associated with the proposition that it is medicine's conceptual allegiance to the ideological distinctions of modernity that so problematize current accounts of empathy. The first is to call attention to the relevance of Foucauldian perspectives for empathy in medicine, a point also raised briefly by Rebecca Garden in her critiques of narrative medicine more generally<sup>9</sup>. Foucault's concept of 'the gaze' (*le regard*) and on the forms of power produced by the clinic has been a critical perspective on the practice and knowledge of biomedicine for some decades<sup>15</sup>. The 'gaze' describes medical ways of knowing that posit the doctor in the position of observer of the patient and his/her disease. This positioning *objectifies* the patient – that is, it produces the patient as the object of knowledge, a passive thing to be known; it is dehumanizing, separating the patient's body from his or her personhood, and rendering it available to be manipulated and known. At the same time the doctor becomes invisible, positioned at the point from which things are seen and known, what Donna Haraway called a 'view from nowhere'<sup>16</sup>.

Empathy has been constructed as a means of bridging the gaze. But by using empathy as a way to 'add on' the 'psychosocial' dimensions of illness – the idea of 'adding on' implies that these are both separate and marginal to the biomedical aspects of illness – this version of empathy instead to *reproduces* the gaze, with its distributing capacity to mark out both the subject and the object, the gazer and the seen<sup>17</sup>. The gaze objectifies; empathy cannot rescue the patient from objectification, it just adds some colour to the object. Garden warns that narrative medicine, which sets out to critique the objectifying and reductionist qualities of biomedicine and to cultivate capacities for empathy in doctors, may often be just another form through which the doctor can come to *regard* the patient: the patient becomes a spectacle of suffering through which the doctor can demonstrate their virtue, commanding and sometimes

appropriating the patient's story<sup>11</sup>. Empathy may become a tool by which the doctor can exercise power - pastoral power, enacted with and through the patient by constructing them as a confessional subject, in need of medical understanding<sup>18</sup>. This is productive power, not repressive power, but it is nonetheless as constraining as it is enabling. Thus, we suggest that the Gaze overdetermines empathy, and this is a problem because it is of questionable ethics and works against the autonomy that empathy is nominally trying to give extension to.

The second issue is that our conceptions of empathy have been fairly *static* and *abstract* entities. The metaphors we use matter for how we are able to conceive of things, and in accounts so far, empathy has been mostly imagined as a possession. Empathy either exists or it doesn't; doctors 'have' it or they don't; it is a cargo, or a level that may be measured; it is a set of mirror neurons, perhaps. This static conception of empathy doesn't allow us to understand much about *what changes* when doctors 'have' empathy. Where does it come from – and how does it shift interactions and produce effects? Static models, or those that reduce the explanation to neurotransmitters, don't tell us much about how empathy is experienced in patient encounters or what happens between the parties involved, and this insight is key for understanding, beyond a warm fuzzy glow, why empathy might matter.

The third issue is that what is missing in all these accounts of empathy are *bodies*: the body of the empathizing doctor is entirely absent, while the body of the sick patient is considered relevant to the technicalities of medicine, but not to empathy. The doctor may have empathic understanding of the patient's physical suffering or sensation, but neither feeling body is theorized as part of what empathy is or how it occurs.

The fourth issue also concerns what accounts of empathy leave out. Currently empathy is understood in an entirely decontextualized fashion: as something germane to the interactions between a doctor and a patient, but not as something influenced by the time, location, space, or other aspects of the event. Empathy is thus separated from health services, hospital rooms, the epistemology of diagnoses, and all the other elements that were necessary to the two actors coming together. Yet the reality is that patient experience is heavily influenced by all these factors, and that what is soothed by empathy is rarely simply the experience of a pathology, but rather the pathology as a located lived experience, embedded in and produced by the set of institutions and social structures in which the patient is enmeshed.

In what follows, therefore, we take Pedersen's and Garden's critiques of empathy seriously. We are interested in a theory of empathy that can engage with the specificities of the context in which it occurs. We are stimulated by Pedersen's emphasis on the importance of hermeneutics in the doctor-patient encounter, and by Garden's consciousness of the ways in which both that encounter and the notions of suffering and illness and virtuous action that structure it are discursively constituted. And we want a theory that can accommodate the many quotidian elements that are critical parts of health care experience.

We think 'empathy' might seem like a very different phenomenon if detached from modernist constructions of medicine and indeed (as we suggest below) of subjectivity itself. Retheorising empathy in this way would be an interesting project for its own sake. But we're also interested because of what insights into therapeutic interaction a

less constrained version of empathy might open up. Here we'd like to recognise affective reality as primary to medical interactions, not just an add-on to the business of physiological intervention.

Nor are we the only ones; very recent scholarship on empathy in medicine has similarly looked for innovations that could circumvent the problematic polarisations between cognition and emotion particularly. A critical shift that many of these works have made is to cease thinking of empathy as something we *have* and to being thinking of it as something we *do*. Thus several recent psychologically-based models of empathy incorporate affective, cognitive and behavioural elements, and draw out – literally – *processes* for how empathy occurs, mapping the pathways that link these elements<sup>4 19 20</sup>. Others have suggested that we understand empathy *performatively*, as something we *enact*, in ways very like – or the same as – emotional labour<sup>19</sup>. While these models do not disrupt or jettison polarities (but merely distribute where they are in the model and specify connections), this shift from having to doing, from static to dynamic models of empathy, open up many new possibilities and insights.

We find this shift compelling and see a rich resource in the humanities that would enable further exploration of what empathy means in medical encounters. One of us has extended the application of a phenomenological approach to empathy<sup>4</sup>, appropriate in part because the concept originated in this philosophical context. Along the phenomenological line it may also be interesting to explore what a Satrean account of emotion could open up in our insights into empathy<sup>21</sup>.

Here we add another possible version of it – a turn toward the more *process* oriented theories and philosophers of the past half century, as expanded by Gilles Deleuze<sup>22</sup> and also with his collaborator Felix Guattari<sup>23</sup>. In comparison with Michel Foucault, other Continental philosophers in the postmodern tradition have had surprisingly little attention within the medical humanities despite their enormous impact in the humanities in general<sup>24</sup>; though perhaps this is unsurprising, given the challenge that poststructuralist and postmodern positions pose to the canon of classic liberal arts education that has been so central in the medical humanities to date. Here we try out what those who start from a deliberately anti-Cartesian position can offer us in a novel theorization of empathy. We draw specifically upon affect theory and emotional geography. These theorists understand affects, that which is "more than and less than rational"<sup>25</sup>, as productive entities, an approach that can be traced to a resurgent interest in Spinozan affects<sup>26</sup>. At minimum, we argue that this perspective offers a way of understanding empathy that attends to its *dynamic* and *transitory* emergence in the specificities of health care: a *located*, *embodied* and *performative* empathy (or empathies); one sensible of its *hermeneutics*, and one in which *both subjectivities* are important. These are all key dimensions of empathy that become 'invisible' in other accounts.

## **A different approach**

Let us begin with an illustration – an illustration of the 'old' concept of medical empathy. In his seminal paper on empathy in medicine, one of the early pieces of thought-provoking interest and advocacy that stimulated research and commentary in the area more than twenty years ago<sup>27</sup>, Howard Spiro relates an anecdote in which

young doctors joke callously about a comatose elderly man until they see a card on the wall near his bed, saying ‘get well soon Grandpa’. This silences them: the patient is jerked from being a passive, physical object defined in terms of the workload and resources it demands, and in terms of the ineffective systems of medical care, suddenly back into personhood. The child’s love and grief become the focal point of a much more reverent response. (Or so we infer from the bare bones of this story). This, says Spiro, is empathy – at least for the child, if not quite for the patient. The cargo of empathy (his term) with which these students entered the study of medicine has been slowly jettisoned as a result of the cultivation of distance and dispassion through practices such as dissection and pathology and the weariness of residency – that is, through the objectifying gaze; but in this moment, a little of that cargo gets hauled back from the deep.

At first glance, this anecdote, and the paper that surrounds it, illustrate our contentions above: in it empathy goes mostly undefined, but is considered as a possession; it lets in emotion, but in no way disrupts or connects with the technicalities of medicine. But the important part of this anecdote is not what characteristics the students ‘have’. It’s what *happens* that is important: that something changes. And to understand that, we have to start with how we understand the selves involved. We have to start by retheorising subjectivity.

### **Becoming equal to what happens in theory: rethinking subjectivity**

While we may feel empathic *happening* as an affecting force, becoming sensible to what happened is helped by (we suggest: requires us) to turn away from the ‘rational’ ‘cognitive’ approaches often associated with Cartesian and neo-Kantian thought. (Of course these days there are those who theorise both rationality and cognition in non-Cartesian, multivalent ways, but the dominant modernist paradigm that construes rationality and cognition as opposite to emotion strongly persists in much medical and scientific discourse). *Affect* theorists made just this turn<sup>28</sup>. We suggest that we use the traditions of affect theory to help us see *what happens* in empathy. This is no easy move to make given the ubiquity of such rationalist cognitive approaches in western cultures. However we feel that it is a necessary one in order to see what changes if we use it to allow a different version of the reality of empathy to come into view.

Theorising affect is often seen to require staking an alternative position to established ideas of mind and body. Benedict de Spinoza (1632-1677) famously rejected Descartes’ mind/body dualism, insisting rather that mind and the body ought to be understood as one thing<sup>29</sup>. He also saw personhood dynamically, as something that changed over time, and he framed personhood in terms of actions, rather than in terms of qualities or possessions. Similarly, David Hume’s claim—that many of our emotional states arise from intersubjectivity (that is, arise from our engagement with others rather than being solely internally founded)—suggests that possibility that we could productively think about consciousness or existence in terms of continually evolving emotional transference constantly shaped by, and shaping, its context<sup>14</sup>. The first difficult move here is that affect theory sees subjectivity as contingent. It is not a thing. It is, itself, dynamic and constantly being produced.

For affect theorists the body is not merely influenced after the fact by affectedness, which is how earlier versions of empathy would have it. You have a feeling (say, of identification with a patient), it affects you. Affect theorists go further and suggest that a body is *determined in its capacities* by how it is affected. A body's capacities are also not things, but are also dynamic and constantly being produced; they are, therefore, transient. Such ideas challenge deeply held ideas of self and subjectivity that are dominant in both medical and broader western cultural models.

Ideas of the self, and how a self relates to other selves, have long been predicated on the assumption that a conscious complete human precedes any interaction that follows. Affect theorists put forward an alternative to this limited view of selfhood when they suggest that the self is contingent upon interactions of embodied selves with both other human and non-human entities. A leading theorist of affect, Brian Massumi puts it thus: "The human is fractalized. It is dispersed across the nodes and transversed by them all in the endless complexity of relay"<sup>30</sup>.

To understand this, we, like Massumi, will use Gilles Deleuze and Felix Guattari's philosophical perspective to think about subjectivity. Together with his collaborator Guattari, Deleuze's philosophical project was to build a metaphysics that matched developments in twentieth century science and society. This was, for him, a philosophy of *difference*<sup>24 31-33</sup>. This constantly-dynamic metaphysics is anti-foundationalist. In it, the concept of multiplicity replaces that of substance: things do not simply 'exist', they are dynamic, multiplicitous, transient entities. Similarly, event replaces essence and virtuality replaces possibility. In this philosophy, *difference* –the difference between self and self, between human and table or between any other two things, is no longer an empirical relation, because the things are not considered to have a prior existence. Instead, difference becomes a transcendental principle that constitutes the sufficient *reason* for empirical diversity. Thus, for example, it is the difference of electrical potential between cloud and ground that constitutes the sufficient reason of the phenomenon of lightning<sup>24</sup>; as it is the tendency to minimize difference in free energy that constitutes sufficient reason for the emergence of both surface tension minimizing bubbles from soap molecules, and bond energy minimizing crystals from sodium chloride solution<sup>34</sup>.

A key conceptual term developed by Deleuze and Guattari is that of the 'Body without Organs (BwO)' to describe a primordial undifferentiated deeper reality underlying a whole that is constructed from parts. Traditional concepts of subjectivity, such as a doctor and a patient, give us the doctor and the patient as stable, separate identities and entities<sup>31</sup>. But these entities are really composed of sets of flows: 'this body without organs is permeated by unformed, unstable matters, by flows in all directions, by free intensities or nomadic singularities, by mad or transitory particles'<sup>23</sup>; they are always being reformed. The BwO does not pertain only to specific individual bodies (or persons), but also refers to the *virtual* dimension of reality (or 'plane of immanence'), in general. This can be thought of as an infinite reservoir of all potentials for material being – sentient or otherwise.

As a description of subjectivity, Deleuze and Guattari separate the pure affected body - the Body without Organs (BwO) - from the fixedly determined identity of any particular human organism. The BwO is traversed by intensities, is affected and affecting, is capable of achieving extension through human and non-human entities, is

always becoming, and never quite fixedly human<sup>30</sup>. There is an inter-penetration of psychic experience and forces of society and nature<sup>31</sup>. By contrast, a body with organs is the transiently fixed body with a limited set of traits, habits, movements, affects, etc. In an elegant paper, Nick Fox has illustrated the utility of this perspective for medicine<sup>31</sup>. For example, it implies that we might allow the identity of the doctor and patient to remain unfixed, and instead, to be contingent upon a dynamic struggle of *territorializing* and *de-territorializing* effects of different psychic, biochemical, social and natural forces. That is to say, diagnoses, medical discourses, different pharmacotherapies, cancer cells, etc, each reconfigure – transiently – the entities we call ‘a doctor’ and ‘a patient’. Such a dynamic understanding of personhood opens up how we see doing and being a doctor and patient; we can see where these transient entities emerge *from* and what in turn emerges next. This perspective also allows us to consider those aspects of empathy that are conspicuously missing in theory to date.

But then how do we understand empathy – or perhaps we should say, but how then is empathy produced (is productive) - in the milieu of these deconstructed bodies, or in medical coming-togethers? Theorizing affect means giving a logical consistency to<sup>30</sup> or, becoming equal to<sup>35</sup>, the *in-between*. We repeat that Deleuze’s critique of the dominant philosophy of Plato, Descartes and Kant was that “intensive differences are subordinated to the extensive structures...they give rise to”<sup>36</sup>. That is, identity subsumes the processes that produced it. Similarly, we suggest that it is useful to see the intensive aspects of empathy as having been subsumed by their end product, conceptually speaking. That is, what we have seen is only the end product - the patient/doctor dyad – and not the processes of empathy as producing this product. Thus ‘old’ versions of empathy have mistakenly ascribed the capacity of empathy to affect change to this end product, that is, to a doctor-self whose response to a patient shifts their therapeutic relation. Now, instead of looking at stable identities that change because of empathy, we are looking at empathy as a thing that transiently produces these identities in particular ways.

### **Becoming equal to what happens in theory: emotional geographies of empathy**

In this section we wish to outline a strategy that will allow an increasing awareness of the specific ways that context and bodies can be said to ‘interpenetrate’ to produce events of empathy. Firstly, we define empathy as excessive. Time and again affect theorists emphasise Spinoza’s observation of the excessive nature of affects; that is, affects exceed what is, spill over, are productive. Exactly what affects are excessive to is the ideal or complete idea of things. “What the complete determination lacks is the whole set of relations belonging to actual existence”<sup>22</sup>. In the particular case of empathy, the idea of the patient and the doctor have been central in predetermining the possibilities of empathy, a move that is counter to the actual and singular events through which empathy occurs. The set of relations that empathy implies meets this criteria of excess when they change things in consultation, by bringing new and unexpected directions or possibilities to the flow of the interaction.

Secondly we define empathy not as an essential type or class of thing, but as unique emergences that are time and space dependent. If we think about empathy as singular events of empathy, or *empathies*, we again expose the limits of dominant theories. Empathy that is felt in consultation, cannot be understood in its excessiveness while retaining “the Kantian imperative to understand the conditions of possible experience

as if from outside and above”<sup>30</sup>. Singular empathies are better understood in terms of the ‘plane of immanence’ (above), part of general reality. The idea of singular empathies also allows us to take account of the significant affective context in which these empathies emerge.

Thirdly, we must have a way of coming to terms with the real existence of empathy in the milieu of medical coming-togethers. As we have seen, medical literature is plagued by metaphors of empathy as trait, level or quality (of a subject). But once we take a Deleuzian approach to subjectivity, these metaphors become meaningless. Instead, a Deleuzian approach would treat empathies, not as emotions or experiences, but as real material entities, part of the vast infinite reservoir of the virtual. The reader may well ask: in what sense can an entity like empathy be real? surely not as real as a doctor and a patient, or a scalpel? But in the Deleuzian framework, the doctor, patient and scalpel are not ‘real’ either, in the sense of fixed entities that then have or create a moment of ‘empathy’; they are sets of flows, transiently produced by their difference from one another. Deleuze’s framework gives entities like empathy (and diagnoses, and cancer cells, etc) an equal ontological status – they are all temporary configurations, produced by and productive of forms of difference - that enables us to catch a glimpse of how empathy might actually work.

Deleuze and Guattari developed a distinction between the *possible* and *real*, on one hand, and the *virtual* and *actual* on the other<sup>22</sup>. It is this insight that will allow us to consider empathies as *real*. The ‘possible’ is that which is an idea (or essence) that may achieve real expression in matter and which Deleuze rejects in favour of the ‘real’, which he split into the virtual - entities that really exist and are capable of *divergent actualization* - and the actual, that which we experience<sup>36</sup>. We understand that singular *empathies* emerge from a consultation space that is prior, or at least simultaneous, to the identities of doctor and patient. In this sense empathy can become more than a (non-real) ideal, but be appreciated as real, singular, emergent (like a soap bubble) and having the capacity to configure affective space; to actualize specific ‘points of inflection’<sup>22</sup>. It is not that empathy changes what is possible for doctors and patients to achieve in medical consultation, but more radically, singular empathies produce particular doctor-bodies and patient-bodies by making them actual (that which we experience) through its operation.

Let us now re-examine Spiro’s example of empathy. Firstly, Spiro’s empathy is an *event* which includes the *intensities* of the card and its linguistic and aesthetic content, the shared understanding of the junior doctors on seeing it, the contagion of shame that is jointly felt and multiplied presumably by the simultaneous recognition of affectedness between the bodies of the doctors, and which stands in such contrast to the jovial nature of the group in the moments prior; and all this in the presence of a body-patient; a man incapacitated and made an object of pity. This event of empathy can therefore be defined *spatially*; by the dimensions of different intensities operating across bodies.

Secondly, this event of empathy is *singular* and *emergent*. That is not to say that this particular event, one may wish to categorise it as one of shame, is not repeatable in type (it is always possible to categorise). But it is more usefully conceived of as emerging from and shaping its *context*; the circulation of affects across bodies participating in this medical ‘coming-together’.

Thirdly, the empathy described by Spiro is productive: it changes things. Whether it actually reflects a real event or is purely fictional, it affects us. If fictional, it remains an expression of the affectedness of the author who, like the little boy penning a get-well card, is overflowing affectedness through the technology of the written word. Assuming it is a valid account of a real event, we can see how it reconfigures the bodies of the rounding doctors. It changes their behaviours in the moments, minutes, hours after the event, and perhaps even goes on to reconfigure their behaviours in their lives or medical careers. Whatever it did, the empathy event was transformative and productive and divergent, and presumably was told to Spiro and then written and communicated in such a way that the medical community could share in the felt experience (and...). Such is the capacity of the singular empathy in its excess to actualize difference from a virtual space. Empathies of this type defy capture in a static idea, but are continually expanding, affecting, ever outward.

Our task in understanding empathy is, therefore, not to discover a generic category of configuration that we can seek to replicate and reproduce in order to continue the discursive work of medicine<sup>23</sup>. Instead, our task in understanding empathy is “much more singularly, endeavouring to configure *a* body and its affect/affectedness”<sup>26</sup>.

This means becoming more aware of the affective reality of the consultation space that medical encounters occupy, as well as exploring the experience of medical subjectivities. As such we suggest conceiving of the affective aspects of empathy not as products of a discrete subjectivity, but as emerging within an ‘emotional geography’<sup>35 37</sup> of bodies becoming ‘empathied’. Such a conception is useful in that it implies a transpersonal consistency of affect that is open to bodies and capable of divergent actualization<sup>22 36</sup>. Furthermore the concept of an emotional geography takes us away from the limitations of conceiving of empathy as a possession or as a limited action by a subject. Instead, empathy can now be conceived of as an emergence within a topological consistency that is capable of folding, flowing, having points of inflection; that is at times experienced as closed or impassable, or characterised by striations and limits, and at other times experienced as open and smooth leading to lines of flight<sup>23 38</sup>. Subjectivities are defined not in isolation, but from within and against the forces of these affecting *spaces* and their linguistic, physiological and non-human extensions<sup>39</sup>. Singular empathies emerge and re-emerge across a real virtual space, continually redefining the space of consultations. Such an emotional geography can include all that is affected and affects the consultation space including doctors, patient, card, journals, medical language and communities, in short all that becomes enmeshed in the affectivity of the event. Not only do empathies change the *content* of the consultation, they can also change the *parameters* of consultation itself, which perhaps explains why we find empathy so powerful in medicine. In contradistinction to the classical doctor/patient dyad, which are – as we have seen – reproduced as separate and hierarchical in classical versions of empathy, *affective empathies* suggest a trans-subjective geography of interaction where overlapping subjects *in*fold context and change the virtual space which they inhabit and lead to divergent actualization.

## Conclusion

We have argued that existing models of medical empathy suppose a pre-existing and separated doctor and patient who are thought to interact through limited mechanism of communication: either body language, written or vocalised language. This model of empathy has always made intersubjectivity a dubious proposition. Further, in traditional accounts of empathy, emotions are troublesome - either suppressed in the pursuit of detachment (doctor) or subjected to inquiry (patient) for the goal of understanding. Such a limited construction is continually challenged by the actual empathic affectivity that is broadly acknowledged to be *felt* in medical consultations.

Our understanding of affects suggest that the reality of singular empathy events would be excessive to this determination, that it would affect bodies, inserting itself into consultations when bodies come together in a given context. Such a reality is beyond the conception of classical metaphysics. As one of us has argued elsewhere, empathy unavoidably suggests a critique of the dualities of subject and object, cognitive and visceral, patient and doctor<sup>4</sup>.

Importantly this account of affect is compatible with neurological capacities of individuals to mirror or anticipate others emotions, to learn behaviours, to enfold cultural fixings, or to have been shaped by evolutionary mechanisms whereby certain reactions or affective states may be 'imprinted'<sup>40</sup> in bodies. It does not deny that contexts affect the way empathy operates in a clinical consultation. Instead, a theory of affective empathies allows for the possibilities of all of the above complexities of medical contexts to operate via bodies coming-together. In Deleuzian language, we might say that residual traces of previous experience are in-folded within and territorialize the BwO, but are enacted and produced in singular ways during consultation where the BwO is affected anew.

For medical students and doctors, their educators and organisers who are hoping to 'increase' empathy, this view of affective empathy has significant implications. While some empathies may involve doctors seeking to cognitively convey empathy (for example, by reproducing certain acts or words that may convey it<sup>41</sup>), we suggest that the student of empathy needs to avoid presupposing what kind of empathy may be conveyed and the manner in which this may occur. Instead, and simply, we need to be open to becoming affected. A multiplicity of empathies is possible in a given situation, as there is a multiplicity of ways that a body can affect and be affected. Thus promoting empathy may mean taking measures to ensure that the doctor and patient are affectively present, to reduce affective states that might impede affective engagement (anxiety, stress, inattention, depression) and to allow medical students and doctors (probably unquantifiable) ways of being that are open to affectedness. This enables us to be cognizant of the multiple aspects of a situation – the space of a treatment or consulting room, the wearing of protective equipment, the ways in which note taking procedures disrupt or facilitate conversation, down to the subtle minutiae of tone, glance and touch – in which empathy might emerge and how it might affect us.

Bodies may benefit from developing their capacities to affect and to become affected. Activities such as reading fiction<sup>42</sup> or attending the theatre<sup>43</sup> have been suggested as ways to increase an individual's empathy. We would however revise the interpretation of these findings and say that if such activities improve empathy, they would do so by configuring bodies toward being affected (rather than a mechanism

of cognitive ‘simulation’ of the other). Rather than increasing an individual’s ‘empathy complement’, such activities enhance a body’s capacities to affect and be affected, opening them to shared affective states that cannot be separated from their emotional context (the theatre experience itself, where and how and why literature is experienced). It is the continuity of affect, the emotional geographies in art and life that form the space of affectivity, the BwO, from which individual empathies can then arise when bodies come together. Future research could consider the organisation of health around emotional geographies (in addition to existing arrangements in which flow of capital, or the abstractions of organs, or disease hierarchies can often determine the structure of health ‘systems’) or connect empathy theory with medical, architectural and cultural research identifying places of healing.

We have outlined two projects here. The first, following from critique of medical empathy in the literature is to sketch a theory of empathy through affect, one that takes into account the excessive capacity of empathy to change medical subjects and objects. The second and simultaneous project is to use the reality of empathy to further contribute to the affective turn and challenge existing ideology around the self and in particular medicalized bodies. Even those unpersuaded by the full extent of the positions outlined here may appreciate, by force of contrast, how different it is to understand empathy as transitory, performative, and dynamic, as opposed to static or purely cognitive; how different it is to understand the empathy as affecting and producing affects in others, as productive and hence active; to see how the body is intrinsic to empathy, one primary way one can be affected. Our application of a Deleuzean framework here is very much merely a beginning; a full Deleuzean theorisation together with its implications for practice may find many possibilities not discussed here. These new vistas are enticing. Empathy as located, embodied, performative, and productive – these are novel and very productive features of empathy to bring into view.

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