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Empathy in the healthcare system: the limits and scope of empathy in public and private systems

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Abstract

In this chapter we examine the two dominant healthcare models, public and private, and discuss the extent to which each model can promote empathetic care. We analyse the moral underpinnings of each model - solidarity and individualism - and examine different justifications for the provision of healthcare under each system.

We argue that empathy exercised by the individual healthcare professional alone is not enough to ensure empathetic care overall. Rather, the healthcare system as a whole needs to embrace empathy as one of its principles and make it the basis on which it operates. Although the professional code teaches doctors and nurses to engage empathetically with their patients, it is challenging for healthcare professionals to develop, maintain and enact empathy in a system that does not support and foster it. Ensuring empathetic care for all can be better achieved in a system that acknowledges people's interdependency and mutual responsibilities.

Introduction

Healthcare professionals are expected to care for their patients in an empathetic way. In fact, empathy is one of the core values of the medical profession. Empathy is the ability to understand a person's stand point, their experience of illness and, through this cognitive resonance, feel motivated to help them. Empathetic doctors and nurses can better care for their patients, by addressing their worries and concerns and providing the right treatment for them. Numerous studies have demonstrated the beneficial effects of empathy on patient outcomes, establishing its crucial role in the provision of good healthcare (Boker et al., 2004, Marcum, 2013, Spiro, 1992, Tsao and Yu, 2016). It is important, therefore, that empathy is embraced and promoted not only by the profession but also by the healthcare system as a whole. We argue that empathy exercised by the individual healthcare professional alone is not enough to ensure empathetic care overall. Rather, the healthcare system as a whole needs to embrace empathy as one of its principles and make it the basis on which it operates. Although the professional code teaches doctors and nurses to engage empathetically with their patients, it is difficult for healthcare professionals to develop and maintain this value in a system that does not support and foster it. Operating as an individual in a system that does not share and support core professional values makes maintaining and enacting these values challenging.

In this paper we examine the two dominant healthcare models, public and private, and discuss the extent to which each model can promote empathetic care. We analyse the moral underpinnings of each model and examine the different justifications for the provision of healthcare under each system. In the public system, provision of healthcare is based on the acknowledgement of interdependence built on the idea of solidarity. In the private system, provision of healthcare is based on the ability to pay or on charity for those who cannot pay. This system is built on the idea of individualism. Individualism promotes personal choice and freedom. On the other hand, solidarity denotes interconnectedness and relatedness. These characteristics of solidarity are also crucial for the development of empathy. Ensuring empathetic care for all can be better achieved in a system that acknowledges people's interdependence and mutual responsibilities.

Empathy in healthcare

Empathy is a fundamental value of the healthcare profession. Expert knowledge and technical skills are essential for doctors and nurses to care for their patients, but it is also important that care is provided in an empathetic way. Empathy is the process that allows an individual to understand the world from another person's standpoint and to join in someone else's experiences and feelings (Hojat et al., 2001, Hojat et al., 2002). Empathy requires an emotional involvement with the other without, however, assuming their emotional position or projecting one's own emotions onto them. It entails the ability to be attentive to the difference between own and others' feelings, which makes empathy distinct from sympathy. Empathy is the precursor of compassion, as it is empathy that drives the desire to act in order to address someone else's needs (Goetz et al., 2010, Nussbaum, 1996). The caring side of healthcare professions demands attention to this skill.

According to Pellegrino, healthcare professionals, by virtue of their role in and importance for society, should be committed not only to technical expertise and knowledge, but also 'to something other than self-interest when providing their services' (Pellegrino, 2002). Unlike a skilled technician, a healthcare professional needs more than just specialist knowledge to provide good care. That is, in order to exercise their profession, doctors and nurses need to feel empathy and be compassionate towards their patients. Healthcare professions embody a particular socio-moral character, expressed through empathy and compassion, which prevents the physician or nurse from viewing their relationship with the patient 'as primarily a commodity transaction, a contract for service or the mere application of scientific knowledge on a sick organism' (Pellegrino, 2002).

Competency and empathy are often described as the two pillars of the healthcare profession. If competency is what allows physicians to provide the right diagnosis, prognosis and treatment, empathy is what allows them to care for their patients and understand their needs. According to Zinn, empathetic care not only allows the healthcare professional to understand the situation from the patient's point of view, but also allows the patient to share their concerns and suffering with their doctor or nurse (Zinn, 1993). As shown elsewhere (Kerasidou and Horn, 2016), empathy is sometimes misrepresented as emotional over-involvement (sympathy) and seen as harmful to the exercise of technically skilled practice. Taking emotions seriously, especially amongst physicians, is often perceived as a sign of weakness or incompetence, or even as being irrelevant to the provision of healthcare. However a number of studies demonstrate the benefit of a healthcare professional's ability to critically reflect on emotions and their ability to feel empathy. Empathy is associated with increased patient satisfaction, improved adherence to therapy, decreased medical errors, fewer malpractice claims, and better health outcomes (Hickson et al., 2002, Riess et al., 2012). On the other hand, studies have suggested that lack of empathy could result in reluctance to seek help even

when needed (Wagner et al., 2007). This highlights the interpersonal character of healthcare. It is much harder for a person to trust, seek help and accept treatment from someone who does not seem to comprehend their situation or care for them. Without empathy as the motivation for and vehicle by which care is delivered, the encounter risks becoming a mere commodity transaction.

Empathy is also important for healthcare professionals' wellbeing. It can help them guard against emotional exhaustion and depression, and deal with emotional distress such as patient suffering, illness and death (Halpern, 2003, Kerasidou and Horn, 2016). Empathy requires reflection and awareness of one's own emotions and feelings as a way of acquiring and maintaining the appropriate mental and emotional resources to deal with the pain and suffering of the people around them. The more people learn to be sensitive and respectful of their own needs and emotions the more sensitive and respectful they become of the needs and emotions of others (Wiklund Gustin and Wagner, 2013, Raab, 2014).

Although empathy is perceived and experienced as a characteristic of the individual doctor or nurse, the development of empathy as a primary motivator of care cannot be left solely in the hands of the healthcare professionals. This is demonstrated by the great attention medical education gives to the development of empathy (Wald, 2015, Dehning et al., 2013, Davis, 1990, Boker et al., 2004, Spiro, 1992, Marcum, 2013). There is a wide recognition that in order for professional values, such as empathy, to be fully developed, the system in which the professionals operate should also be committed to the promotion of these values. Systems and institutions have their own moral character, and as such they have the ability to promote or constrain the actualisation of particular professional attributes and characteristics (MacIntyre, 1985, Titmuss, 1976). Therefore, looking at the way healthcare systems are organised, and the type of values they advocate and promote is important. In what follows, we will discuss the ability of the two dominant healthcare models, private and public, to accommodate and foster empathy as an essential part of the medical profession. We will first outline how the moral underpinnings of each healthcare system link to empathy, and then discuss how empathy is cultivated and encouraged in each system.

The moral underpinnings of the public and the private healthcare models

Public healthcare system and solidarity: acknowledging interdependence

There are different ways to organise healthcare provision. Healthcare can be provided through public funding that is drawn from general taxation or public contributions; this is what we call public healthcare provision. Alternatively, healthcare can be organised as a private service that can be purchased at the point of need by the patient; this is what we will call private healthcare provision. These two ways of providing care are not always mutually exclusive, and various combinations of public and private care provision can co-exist within one system. For example, in the UK, the National Health System (NHS), which is funded through general taxation and national insurance contributions buys many services from private providers, such as psychiatric care and long term residential care (Doyle and Bull, 2000). In the US, although healthcare facilities are largely operated by private companies, still a large proportion of healthcare expenditure is covered by the state, through insurance programs such as Medicare (Himmelstein and Woolhandler, 2016). Also very often healthcare services are provided by the third-sector, such as charities. However, for the purposes of this chapter, we will talk about public and private healthcare systems, not as a way of reflecting *real* systems, but as a tool to differentiate between the different justifications and moral underpinnings of each healthcare system; one that sees care as a right and a good that should be

equally distributed to all members of society (public), and another that understands healthcare as a service to be privately purchased (private). We argue that in a public system healthcare provision is based on the principle of solidarity, whereas in the private system it is based on the principle of individualism and liberty. These different moral underpinnings influence the way empathy is nurtured in each system.

Publicly funded healthcare systems are premised on the principle that there is a positive right to welfare, including healthcare. This means that people have an obligation to fulfil this right not only by refraining from interfering with one's welfare but by actively promoting it (Buchanan, 1987). Daniels justified the positive right to healthcare by arguing that equal access to healthcare is a matter of justice as it protects normal functioning which contributes to protecting equality of opportunity (Daniels et al., 2000). Seeing access to healthcare as a duty of justice, means that it can be enforced. Governments around the world have enforced equal access to healthcare to all members of society either through taxation or compulsory contribution to an insurance system. Citizens pay into the common purse according to their means, and the funds are used to distribute healthcare resources to all citizens, according to their needs. A system that endorses wealth distribution as a way of addressing the needs of those worse off, exhibits the principle of solidarity as it acknowledges the importance of 'mutual respect, personal support and commitment to a common cause' (ter Meulen, 2015). The principle of solidarity that underpins the public healthcare system emphasises the interdependency of members of a society, and their duties to each other.

Durkheim was the first to develop an account of social solidarity and individuals' interrelatedness with each other. He showed that individualised modern societies that do not depend anymore on strong familial bonds and traditional values, maintain their social order by recognising the extent to which each of their members rely on each other (Durkheim, 2014). Durkheim called this 'organic solidarity'; the social bond emerging through the recognition of individual needs and of shared duties to address those needs. In the healthcare context, it is this acknowledgement of interdependence and of the importance of social cohesion that creates the moral commitment of a society to accept the equal distribution of goods in order to guarantee equal access to care. Such a moral commitment, or 'collective consciousness' (Durkheim, 2014), strengthens the social ties and encourages relatedness to each other (MacIntyre, 1985, Durkheim, 2012). The public healthcare system is thus based on the moral value of reciprocal responsibility, which reflects a feeling of belonging together and a relationship of mutual support and cooperative practice that aims to a greater good (ter Meulen, 2015). As we will develop later, these feelings of responsibility, and recognition of obligations toward all members of society imply empathy with the conditions of others and a willingness to care (Stjernø, 2009: 185).

Private healthcare and individualism: choosing to benefit others (or not)

Private healthcare systems are premised on the ideals of the right to liberty and the right to property. These (and the right to life) are described as natural rights – rights we all possess in virtue of our nature and which are distinguished from social rights, such as the right to healthcare, imposed by government or society. Social rights can be accepted only as long as they do not infringe upon natural rights. In the case of a universal access to healthcare, ensuring such a right would require wealth redistribution by the state (e.g. general taxation). Yet, general taxation to safeguard a social right in effect violates people's natural rights to liberty (freedom of choice) and property (freedom to enjoy one's fruits of labour). According to Nozick, the state should not impose moral obligations on

its citizens, including coercing citizens to donate their resources to assist others. Even if such an obligation would be socially optimising, doing so would be analogous to forced labour (Nozick, 2013). Individuals should be allowed to purchase healthcare privately, and thus exercise their right to liberty and property as well as promote their own conception of good. Purchasing healthcare privately promotes individual freedom and ensures appropriate use of resources (Epstein, 1997). The principle that underpins the private healthcare system is individualism. Individuals are free to exercise their right to pursuit the good life as they see it, without being coerced or constrained by externally imposed moral norms.

An unavoidable consequence of a private system, however, is that some individuals might find themselves in a situation where they cannot afford their appropriate care (e.g. very expensive cancer treatment). In those cases, the only acceptable way for these individuals' needs to be met is through charity. Charity, one's resolve to freely give to others, is the free expression of one's moral code and character.[1] A person can decide to charitably give away their property, or part of it, to another for the other person's benefit (beneficence) in accordance with their very own social and moral convictions. The exercise of charity respects both the right to liberty (the giver decides how to use their property) and property (the donation is voluntary), and is consistent with the principle of individualism. A state-enforced charity (e.g. wealth redistribution through taxation) would not only violate natural rights, but would also undermine the nature of charity by making it an enforceable duty, rather than an autonomous expression of free choice and moral character.

The idea of individual freedom of choice defended by the private healthcare system contrasts with the collective aspects of solidarity found in the public healthcare system. The values of individual freedom and possibility of choice challenge the idea of interdependency, mutual responsibility and collective solidarity. The private healthcare system does not foreclose concern and care for those who cannot afford it, but neither does it require it. Its members are not expected to consider their relatedness to each other, as it does not recognise any mutuality or commonality amongst them. Rather, it expects them to operate on the basis of rational self-interest. Even though charity indicates generosity, List argues that it is often construed as connoting "self-sacrifice" (List, 2011). The individualistic aspect of charity does not presuppose a shared value system. That is why it leaves the distribution of benefits in the hands of individuals. As we will develop in the following section, the absence of mutual responsibility and recognition for each other's needs does not encourage engagement with other persons' perspectives which is fundamental for the development of empathy.

The impact of different moral underpinnings on empathetic perspective taking

The scope of empathy in the public healthcare system

We argued above that a public healthcare system is premised on the principle of solidarity, recognises commonality and mutuality, and relies on a symmetric relationship between people. Solidarity shares features with charity in as much as both principles describe one's willingness to bear costs to assist others, 'but they differ importantly with regards to the element of sameness and the type of relationship between giver and receiver' (Prainsack and Buyx, 2012). The feeling of belonging together makes it easier to relate to each other and enhances the ability to see the world

[1] The virtue of charity has its roots in the Christian tradition. Along with faith and hope, it is one of the three theological virtues listed by Aquinas. For Aquinas charity is a self-perfecting virtue, one that aims at perfecting one's ability to love God, and by extension everything that exists, since God is the master and creator of all.

through the eyes of the other. This process is fundamental for the development and exercise of empathy (Stjernø, 2009). Fostering empathy within society facilitates the process of wealth redistribution, which is seen as part of one's social responsibility. The inter-subjectivity and concern for the wellbeing of others provides the moral ground for the public healthcare model.

At this point it is important to emphasise the iterative relationship between developing particular principles and aptitudes at a systemic level and at an individual or professional level. A healthcare system that endorses and promotes a strong empathetic regard for the welfare of others, facilitates the exercise of empathy in the delivery of care. Studies have demonstrated that empathy is easier to achieve when it is directed towards people with whom we identify, e.g. people from similar social and educational backgrounds (Stürmer et al., 2005), but not so easy in the absence of a sense of mutuality with the other. As de Waal observes, it is more difficult to be empathetic towards and identify with 'people whom we see as different or belonging to another group' (De Waal, 2009). A considerable amount of moral work would be required from the individual to overcome embedded prejudices. Promotion of social cohesion, therefore, becomes crucially important for the provision of empathetic care. A healthcare system that is built on the principles of solidarity and social responsibility encourages relatedness with people from different backgrounds and social groups, and thus promotes social cohesion which facilitates the development of empathy. Empathetic insight and compassionate treatment are part of the requirements of the medical profession. Healthcare professionals ought to deliver empathy and compassion as much as they ought to deliver competent clinical care. Therefore, a solidarity-based healthcare system supports doctors and nurses in the exercise of their professional duties. It trains and educates professionals to develop the norms of reciprocity and care of each other (Stjernø, 2009: 298). The moral character of the profession aligns with the moral character of the healthcare system, providing a better ground for the exercise and development of empathetic care.

Healthcare systems can play an important normative function by educating professionals to develop norms and moral skills. The normative relationship between the system and the professionals who operate moves both ways. The profession has the ability to influence the way that care is provided, but the ability of the system to foster or constrain special norms should not be underestimated. Titmuss, for example, argues that a healthcare system that recognises everybody's right to care fosters solidarity and social inclusion (Titmuss and Seldon, 1968). Buchanan also demonstrates how social institutions and systems can inculcate beliefs and encourage moral behaviour (Buchanan, 2002). Pellegrino discusses this in relation to the healthcare profession as a meeting of ethics and *polis*. The values of the social system need to support and nurture the particular values embedded in the healthcare profession (Pellegrino, 2002). A solidaristic healthcare system would, therefore, allow empathy in the provision of care to flourish. Furthermore, understanding empathetic care as an expression of solidarity rather than charity, underlines the belief that all patients are equally entitled to it.

The scope of empathy in the private healthcare system

The principles of liberty and individualism that underpins the private healthcare system do not presuppose a moral commitment to common values (other than those of liberty and individualism). Rather, each individual is free to form their own beliefs of what is good. In this way, it neither encourages nor inhibits individuals to, for example, act charitably towards others. In a private healthcare system, there is no expectation to feel social responsibility or to recognise the needs of others. Although the healthcare profession endorses empathy as a core principle, the healthcare system itself remains agnostic towards the need for and importance of empathetic care. This does not mean, however, that healthcare in a private system consistently lacks empathy. Individual

doctors and nurses can choose to be empathetic, and compassionate towards their patients, even at a cost to themselves. The private system, by allowing individual morality to emerge, creates room for values like charity to function, but it has no interest in promoting this behaviour. In other words, this system does not foster a moral commitment to charity, but leaves it to the individual to decide whether they would like to incorporate it into their own personal moral habitus. Yet, reliance on charity as a way of delivery of care can be problematic. Even the most fervent supporters of a private system admit that it is unlikely that all healthcare needs could be met by relying only on charity (Epstein, 1997). This is a system that is based primarily on self-interest, which does not actively invite people to think about the needs of others. In this way, it refrains from developing social cohesion and a sense of mutuality, which can inhibit the development of empathy.

But how detrimental is the lack of clear moral direction for the delivery of empathetic care in a private system? Consider these two possible ways in which the provision of empathetic care might be impeded in such as system. First, healthcare professionals might fail to develop empathy towards all patients. The private healthcare system is an exclusive system in so far as it offers care only to those who can pay for it. Those who cannot afford to pay for their healthcare are positioned outside the remits of the doctor's or nurse's professional responsibility. A healthcare professional might, therefore, feel less committed towards these patients. One could question, therefore, whether a physician or a nurse who reserves their empathy only for those patients who can pay, can still be said to possess the professional trait of empathy. However, to understand this case just as a failure of the individual to correctly apply empathy and compassion in his everyday dealings would be short-sighted and incomplete, argues Buchanan. This is because such an analysis would ignore the role institutions play in promoting particular behaviour and (mis)guide action (Buchanan, 2002). If the healthcare professional decides to treat the non-paying patient out of charity, this would be seen as going beyond the expectations of the system. Such an act would be commendable, especially in situations where caring for such patients can come at a high personal cost for the healthcare professional. Yet, it is questionable for how long individuals could remain charitable in a system that is indifferent to such acts. An individual's moral resources could be quickly depleted, often leading to burnout (Preciado Serrano et al., 2010), or moral aspirations abandoned when operating in challenging conditions. A recent study that investigated the experiences of Greek healthcare professionals working under austerity in resource-poor and understaffed environment revealed that even though they tried to maintain empathetic care in this adverse environment as best as they could, they expressed their worries and concern about whether they would be able to maintain the 'fight' for long (Kerasidou et al., 2016). Of course, one could point to the continuous existence of healthcare charities as a demonstration that individual heroism is sustainable. Furthermore, it could be argued that those who will be providing healthcare out of charity and those choosing to work in charitable healthcare institutions, will have a moral attitude and character disposition conducive to empathy and compassion. It is likely therefore, that empathetic care would be more readily available in a private healthcare system, than in a public one. However, the fact that charities are consistently unable to meet the needs of all those who cannot pay for their healthcare, proves that relying on charity for empathetic care is ineffective.

Second, an exclusive system does not foster empathy towards those who are marginalised. As Segal describes, lack of empathy and interest in understanding others' situations can lead to blame culture where out-groups are held responsible for their own misfortune (Segal, 2011). Glick develops the concept of the 'ideological model of scapegoating'. According to Glick, scapegoating is the result of trying to explain the misfortune of those who are seen as different and unworthy of empathy (Glick, 2005, Glick, 2002). The unwillingness of an exclusive system to understand other persons' different social, economic and health situation can lead to stereotypes that serve as rationale for the hardship

they face. The endorsement of empathy as a professional skill might help doctors and nurses avoid making this type of value judgements for their patients. However, professionals who operate in a system that does not support or encourage the promotion of mutuality between diverse groups might find it difficult to treat 'undeserving' patients the same as 'deserving' ones. They might be less inclined to spend time to counsel, comfort and explain things to 'undeserving' patients, out of concern that their time could be better used caring for those who merit it. As Segal argues, 'empathy that is informed by strong social values such as social responsibility and social justice can overcome stereotyping and blaming of out-groups' (Segal, 2011: 271). Hence, a system that emphasises interdependence and mutual responsibility could help avoid the stigmatisation and blaming of those who are marginalised.

Conclusion

Mutuality and relatedness are fundamental for the development of empathy. Solidaristic systems aim at promoting interrelatedness between people as a way of building social cohesion and supporting acceptance of social responsibilities. A healthcare system that is founded on the principle of solidarity, acknowledges the right to healthcare for all on the basis of mutuality and dependency with one another. The acknowledgement of the relatedness with individual patients and the recognition of their perspectives is the prerequisite for empathetic care. In a solidaristic healthcare system, providing appropriate care to everyone becomes a value of the whole system and not only a value of the profession or of the individual. Under these conditions, it is easier to ensure that empathy is present at the healthcare professional/patient encounter.

On the other hand, a healthcare system that is premised on the principles of liberty and individuality is not concerned with the promotion of a sense of mutuality and social cohesion. It is an exclusive system that provides care only to those who can afford it. For those who cannot afford to pay for their care, charity can fill the space of solidarity. Charitable care however relies solely on the motivation of the individual. Charity is not a systemic value or characteristic. Healthcare professionals may still be committed to the provision of empathetic care, yet, maintaining this skill is more difficult in a system committed to other values that do not include charity and empathy. Therefore, if the goal is to provide good care to all, then endorsing a system that is premised on the principle of solidarity rather than one supported by individualism should be preferred.

References

Boker, J. R., Shapiro, J. & Morrison, E. 2004. Teaching empathy to first year medical students: evaluation of an elective literature and medicine course. *Education for health,* 17**,** 73-84.

Buchanan, A. 1987. Justice and Charity. *Ethics,* 97**,** 558-575.

Buchanan, A. 2002. Social moral epistemology. *Social Philosophy and Policy,* 19**,** 126-152.

Daniels, N., Kennedy, B., Kawachi, I., Cohen, J. & Rogers, J. 2000. *Is inequality bad for our health?,* Boston, Beacon Press.

Davis, C. M. 1990. What is empathy, and can empathy be taught? *Physical therapy,* 70**,** 707-711.

De Waal, F. 2009. *Primates and philosophers: How morality evolved*, Princeton University Press.

Dehning, S., Gasperi, S., Krause, D., Meyer, S., Reiss, E., Burger, M., Jacobs, F., Buchheim, A., Mueller, N. & Siebeck, M. 2013. Emotional and Cognitive Empathy in First-Year Medical Students. *ISRN Psychiatry,* 2013**,** 6.

Doyle, Y. & Bull, A. 2000. Role of private sector in United Kingdom healthcare system. *BMJ: British Medical Journal,* 321**,** 563.
Durkheim, E. 2012. *Moral education*, Courier Corporation.
Durkheim, E. 2014. *The division of labor in society*, Simon and Schuster.
Epstein, R. 1997. *Mortal peril*, Basic Books.
Glick, P. 2002. Sacrificial Lambs Dressed in Wolves' Clothing. *Understanding genocide: The social psychology of the Holocaust***,** 113.
Glick, P. 2005. Choice of scapegoats. *On the nature of prejudice,* 50**,** 244-261.
Goetz, J. L., Keltner, D. & Simon-Thomas, E. 2010. Compassion: An Evolutionary Analysis and Empirical Review. *Psychological bulletin,* 136**,** 351-374.
Halpern, J. 2003. What is clinical empathy? *Journal of General Internal Medicine,* 18**,** 670-674.
Hickson, G. B., Federspiel, C. F., Pichert, J. W., Miller, C. S., Gauld-Jaeger, J. & Bost, P. 2002. Patient complaints and malpractice risk. *JAMA,* 287**,** 2951-2957.
Himmelstein, D. U. & Woolhandler, S. 2016. The Current and Projected Taxpayer Shares of US Health Costs. *American Journal of Public Health,* 106**,** 449-452.
Hojay, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Vergare, M. & Magee, M. 2002. Physician Empathy: Definition, Components, Measurement, and Relationship to Gender and Specialty. *American Journal of Psychiatry,* 159**,** 1563-1569.
Hojat, M., Mangione, S., Nasca, T. J., Cohen, M. J., Gonnella, J. S., Erdmann, J. B., Veloski, J. & Magee, M. 2001. The Jefferson Scale of Physician Empathy: development and preliminary psychometric data. *Educational and Psychological Measurement,* 61**,** 349-365.
Kerasidou, A. & Horn, R. 2016. Making space for empathy: supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics,* 17**,** 8.
Kerasidou, A., Kingori, P. & Legido-Quigley, H. 2016. "You have to keep fighting": maintaining healthcare services and professionalism on the frontline of austerity in Greece. *International Journal for Equity in Health,* 15**,** 1-10.
List, J. M. 2011. Beyond charity—social justice and health care. *Virtual Mentor,* 13**,** 565.
Macintyre, A. 1985. *After Virtue,* London, Duckworth.
Marcum, J. A. 2013. The Role of Empathy and Wisdom in Medical Practice and Pedagogy: Confronting the Hidden Curriculum. *Journal of Biomedical Education,* 2013**,** 8.
Nozick, R. 2013. *Anarchy, state, and utopia*, Basic books.
Nussbaum, M. 1996. Compassion: The Basic Social Emotion. *Social Philosophy and Policy,* 13**,** 27-58.
Pellegrino, E. D. 2002. Professionalism, profession and the virtues of the good physician. *Mt Sinai J Med,* 69**,** 378-84.
Prainsack, B. & Buyx, A. 2012. Solidarity in contemporary bioethics - Towards a new approachs. *Bioethics,* 26**,** 343-350.
Preciado Serrano, M. D. L., Salas Sanchez, E., Franco Chavez, S. & Vazquez Goni, J. 2010. Psychosocial risk, burnout and emotional labour exhaustion in physicians of a charity institution. *Revista Cubana de Salud y Trabajo,* 11**,** 3-8.
Raab, K. 2014. Mindfulness, self-compassion, and empathy among health care professionals: a review of the literature. *J Health Care Chaplain,* 20**,** 95-108.
Riess, H., Kelley, J. M., Bailey, R. W., Dunn, E. J. & Phillips, M. 2012. Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. *Journal of General Internal Medicine,* 27**,** 1280-1286.
Segal, E. A. 2011. Social empathy: A model built on empathy, contextual understanding, and social responsibility that promotes social justice. *Journal of Social Service Research,* 37**,** 266-277.
Spiro, H. 1992. What is empathy and can it be taught? *Annals of Internal Medicine,* 116**,** 843-846.
Stjerno, S. 2009. *Solidarity in Europe: The history of an idea*, Cambridge University Press.
Stuermer, S., Snyder, M. & Omoto, A. M. 2005. Prosocial emotions and helping: the moderating role of group membership. *Journal of personality and social psychology,* 88**,** 532.

Ter Meulen, R. 2015. Solidarity and Justice in Health Care. A Critical Analysis of their Relationship. *Diametros,* 43**,** 1-20.
Titmuss, R. M. 1976. *Commitment to welfare*, Routledge.
Titmuss, R. M. & SELDON, A. 1968. Commitment to Welfare*. *Social Policy & Administration,* 2**,** 196-200.
Tsao, P. & Yu, C. H. 2016. "There's no billing code for empathy" - Animated comics remind medical students of empathy: a qualitative study. *BMC Medical Education,* 16**,** 204.
Wagner, P., Hendrich, J., Moseley, G. & Hudson, V. 2007. Defining medical professionalism: a qualitative study. *Medical Education,* 41**,** 288-294.
Wald, H. S. 2015. Professional identity (trans)formation in medical education: reflection, relationship, resilience. *Acad Med,* 90**,** 701-6.
Wiklund Gustin, L. & Wagner, L. 2013. The butterfly effect of caring – clinical nursing teachers' understanding of self-compassion as a source to compassionate care. *Scandinavian Journal of Caring Sciences,* 27**,** 175-183.
Zinn, W. 1993. The empathic physician. *Archives of Internal Medicine,* 153**,** 306-312.