



Reconstructing the concept of empathy: an analysis of Japanese doctors' narratives of their experiences with illness

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Abstract

The ability of doctors to empathise with patients is a crucial concern in establishing humanistic medicine. Therefore, the cultivation of this ability has been discussed extensively in medical education. One theory suggests that the experience of patienthood can increase empathy among doctors. This theory is supported by previous research that published doctors' illness narratives. However, the concept of empathy has been ambiguously defined in academic fields, including medicine; therefore, analysing how doctors experience 'empathy' in their interactions with patients is difficult. Our research question is how doctors who became patients describe the relationship between their illness experiences and the interactions with patients after their illness. To this end, this paper initially tracks the debates on 'empathy' in medicine and other disciplines, to develop a lens for analysing doctors' illness narratives. Next, we conduct a narrative analysis of illness stories from 18 Japanese medical doctors who became patients. Our analysis supports the traditional idea that an illness can enable a doctor to become more empathetic. However, this is overly simplistic; how doctors experience and subsequently process their illness is more complex. Moreover, this notion can disregard doctors' suffering in these circumstances, and fail to represent the often-lengthy process of mastering 'empathy' based on their experiences. Therefore, our analysis deconstructed the concept of 'empathy', showing that it can appear in various ways. Further research is required to elucidate how empathy is cultivated during the process of transformation of doctors' illnesses, focusing on their communities and practices.

Keywords Clinical skills · Education · Empathy · Illness narratives · Doctors' suffering

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Introduction

‘Doctors who have suffered from an illness and experienced pain understand patients’ suffering’ (Murakami and Hinohara, 2003, p. 31).

The quoted text is by Hinohara Shigeaki (1911–2017), a renowned Japanese physician (Stafford, 2017) who became ill with tuberculosis in his twenties. When experiencing illness, the doctor is also a patient; thus, they are in the position to acquire a deeper understanding of the patient’s experience (Rosenbaum, 1991). This is poignantly portrayed in the film ‘The Doctor’ (directed by Randa Haines in 1991), where a skilful but arrogant surgeon becomes cognisant of his patients’ fragility and anxiety after developing laryngeal cancer. His experience of being a patient led him to become a more compassionate and understanding practitioner (Rosenbaum, 1991). In terms of formal research, previous studies of doctors’ illnesses have revealed how doctors gained awareness of patients’ perspectives after experiencing illness and how doctors who returned to work felt greater emotional empathy (or vicarious empathy)—considered the same as sympathy—and cognitive empathy towards patients, showed improved communication skills and became more proactive about patient care (Fox et al., 2009; Hahn, 1996; Ingstad & Christie, 2001; Klitzman, 2008). Published narrative accounts of doctors’ illnesses indicate that doctors learn much about medical practice by being patients (Jones, 2005; Mandell and Spiro, 1987; Murakami and Hinohara, 2003; Takaku, 2007). These experiences contribute to the improvement of their medical practice and, consequently, the health care system (Haver, 2010; Jones, 2005; Murakami and Hinohara, 2003; Onji, 1989; Takaku, 2007).

The central premise of this body of literature has been that experiencing what others have lived through increases empathy; the idea is that once wounded, a person can understand the pain of others’ suffering. This has been termed the ‘wounded healer effect’ (Jackson, 2001). The notion of a wounded healer is not new; it dates far back to the ancient Greek mythological figure, Chiron, a wounded healer centaur and teacher of Asclepius, the God of healing. In the nineteenth century, Carl Jung noted that a psychoanalyst’s self-understanding and their own experiences of pain result in the capacity to accept others’ suffering; he used the expression ‘a wounded physician’ (as cited in Jackson, 2001) to describe this phenomenon.

This notion of the ‘wounded physician’ has appeared in previous studies referring to doctors who have experienced illness (Hahn, 1996; Klitzman, 2008). Hahn (1996) analysed doctors’ illness narratives and reported similarity between shamans and physicians turning-patients, both of whom had a deeper understanding of others’ pain and suffering because of their own personal experiences with illness. By interviewing doctors with experiences of illness, Klitzman (2008) documented that the doctors gained wisdom through illness; he also suggested possibilities for using doctors’ illness narratives as educational tools to nurture doctors so that they improve their practice.

Based on the idea that the ‘wounded healer effect’ (Jackson, 2001) has use in medical education for developing empathy, Hojat (2016, pp. 224–225) introduced studies in his literature review highlighting that hospitalisation experiences helped nurture empathy in medical students. For example, Wilkes et al. (2002) conducted a study wherein healthy second-year students at the University of California-Los Angeles Medical School participated in pseudo-hospitalisation and concluded that the experiences enhanced students’ understanding of patients’ problems. Another literature review determined that experiential learning interventions increased empathy in medical students (Batt-Rawden et al., 2013). Furthermore, students’ engagement in reflective writing about their experiences with

illness is another method of becoming aware of patients' suffering (Dasgupta & Charon, 2004).

However, this focus on doctors' experiences as patients for educational purposes overlooks other phenomena, such as the effect of their experiences on the doctor-patient interaction and the meanings cultivated through these interactions. Furthermore, the conceptualisation of 'empathy' has evoked debates in the medical field (Garden, 2007; Halpern, 2001; Hojat, 2016; Hooker, 2015; Macnaughton, 2009; Pedersen, 2009; Ponnampereuma et al., 2019; Preusche & Lamm, 2016), which have confused the discourse around the concept in medical education. Some scholars (Hojat et al., 2001; Pannampereuma et al., 2019) prioritise the cognitive aspect of empathy over the emotional one, whereas others (Halpern, 2001; Hooker, 2015; Macnaughton, 2009; Pedersen, 2009) argue that the emotional nature of empathy should be considered. This debate aligns with the mind/body and objective/subjective dichotomy (Hooker, 2015). Therefore, in this study we first discussed the definitions of empathy in medical education, and then clarified our own perspective on empathy. To broaden our viewpoint, we referred to the interpretation of empathy by scholars in other disciplines (Bubandt & Willerslev, 2015; Ganczarek et al., 2018; Hollan & Throop, 2011). This was followed by an examination of Japanese doctors' narratives regarding the influence of their illnesses on their medical practice, especially while interacting with patients, and the relationship between empathy and illness experience. Our analysis of these narratives indicates a possibility of reconstructing the concept of empathy and resituating doctors' illness experiences in both clinical contexts and medical education.

Empathy in medical education and its definitions

Empathy has been defined in various ways in extant research, resulting in a lack of clarity for its role in medical education (Committee on Professionalism and Behavioural Sciences et al., 2017; Garden, 2007; Hojat, 2016; Hooker, 2015; Macnaughton, 2009; Pedersen, 2009; Preusche & Lamm, 2016).

Hojat (2016) defined empathy in clinical contexts and medical education as the cognitive understanding of a patient's suffering and the ability to apply this understanding to patient care; this definition is different from emotional empathy (or vicarious empathy)—considered the same as sympathy—as excessive emotional empathy (sympathy) can overwhelm doctors and hinder their professional judgement and performance. Based on this notion, Hojat (2016) developed a tool for measuring empathy among medical students and health care professionals—the Jefferson Scale of Empathy (JSE)—and used it to measure the empathy of medical students and professionals in several countries (Hojat et al., 2018). This scale enabled measurements of the effectiveness of medical education in improving students' empathy to compare their empathy levels and related elements across cultures and ethnicities (Hojat, 2016; Ponnampereuma et al., 2019).

However, Pedersen (2009), who has worked with medical ethics and communication, rejected Hojat et al.'s (2001) definition of empathy, arguing that cognitive empathy cannot be considered separate from sympathy (emotional empathy). Moreover, to some extent, others' emotions and sensations can be unintentionally experienced when one understands another's situation. Preusche and Lamm (2016) state that neuroscience supports the idea that cognitive and emotional aspects of empathy are inseparable, extrapolating from studies showing the biological mechanisms of empathy in the brain.

Hooker (2015), from philosophical and historical standpoints, introduced a phenomenological perspective on empathy; this perspective is based on phenomenology as a

branch of philosophy, which has broadly influenced social sciences, such as anthropology (Ram & Houston, 2015), psychology (Langdrige, 2018), and educational studies (Van Manen & Adams, 2010), either as a perspective or as an orientation. The research methodologies based on the phenomenological perspective vary but commonly focus on the lived experiences of the research participants. Based on this perspective, Hooker (2015) criticised empathy in medical education as having been reduced to either an intentional quality, such as an acquired skill or behaviour, or an inherent one, such as a characteristic or trait. She furthered the critique and elucidated the concept of cognitive empathy in medicine as having reproduced the idea of the modern dichotomy, for example, the subjective/objective, mind/body, and doctor/patient dichotomies. She argued that the idea of empathy as the ability to understand others cognitively separates the subject (empathising) and object (being empathised with), overlooking the subjective and intersubjective nature of empathy. Moreover, examining the origin of the concept within the phenomenological tradition, she introduced the notion that ‘all human knowledge is necessarily and unavoidably embodied; humans only know anything through perception’ (Hooker, 2015).

This embodied nature of empathy could be understood via the German notion of ‘*Einfühlung*,’ meaning ‘feeling into’—translated as ‘empathy’ in English in the early twentieth century—which was theoretically elaborated in the field of aesthetics in the nineteenth and twentieth centuries by the German philosopher Robert Vischer, and the psychologist Theodore Lipps (Ganczarek et al., 2018; Hooker, 2015). Ganczarek et al. offered a psychological perspective, introducing that ‘*Einfühlung* refers to an act of projecting oneself into another body and environment’ (Ganczarek et al., 2018, p. 141). This implies that one’s bodily sensations, emotions, or mood can be shared by or extended to others using imagination, assuming that other people are ‘people-with-minds-like-ourselves’. In this sense, empathy is embodied while also being experiential, interpretive, and social, all of which are phenomenological components (Hooker, 2015).

The social aspect of empathy has been elaborated further in anthropology. As anthropologists Hollan and Throop (2011) pointed out, an individual’s cultural context dictates their ability to empathise with others and may make it difficult for them to understand the experience of a person from a different cultural background.

In addition, the relationship between an empathiser and the individual who is empathised with should be considered important as empathy can give rise to situations in which the individual receiving empathy is unwilling to be empathised with, and the empathiser intends to control the one receiving empathy (Bubandt & Willerslev, 2015). This dark aspect of empathy, in which one influences and controls others by vicariously empathising with them, was introduced by anthropologists Bubandt and Willerslev (2015). An example from their study concerned moose hunting practices in Siberia. To kill a moose, a hunter approaches it while wearing another moose’s skin as camouflage. Thus, the hunter vicariously empathises with the moose without sharing its emotions. Therefore, the moose is deceived and controlled by the hunter/empathiser.

In clinical contexts, a doctor can vicariously empathise with patients by imagining the patients’ thoughts and emotions, which can help patients feel understood and make them more eager to conform to the doctor’s advice. Whether the doctor intends to do so or not, this empathy can become a violent act if patients are unwilling to be empathised with or if they feel controlled by this vicarious empathy.

When we considered this vicariousness as an element of empathy, we found that empathy can be social, mimetic, and even violent. Thus, the usage of the term ‘empathy’ is confusing owing to its multiple definitions in medical education and other disciplines.

To explore the influence of doctors' illness on their medical practice, Hooker (2015) and other scholars (Halpern, 2001; Macnaughton, 2009; Pedersen, 2009) prompted us to consider that empathy is not merely an efficient skill needed for the practice of medicine but can also be a perspective for doctor-patient interactions. Under this perspective, empathy is embodied, experiential, interpretive, and social, as discussed earlier. However, we have not directly explored the social aspects of empathy that are reflected in anthropology. Nevertheless, this notion influenced our perspective on empathy.

Reflecting on the embodied, experiential, and interpretive perspectives of empathy, we explored how doctors described the relationship between their experiences of illness and their responses to patients in medical practice. Our research sought to address the following research question: How do doctors describe the influence of their illnesses on their medical practice, especially while interacting with patients? Through dialogic/performative narrative analysis (NA) of oral narratives collected via interviews, we examined how the doctors' narratives correlated with the typical discourse. Such a discourse suggested that doctors who had suffered from an illness and experienced pain, understood their patients' suffering. Based on the results of our study, we tried to reconceptualise empathy and resituate doctors' illness experiences in medical education and clinical contexts.

Method

Narrative analysis

This study used the NA method. Narratives increase our understanding of experiences, in this case, doctors' experiences of patienthood. Mishler (1995), a narrative scholar, maintains that experiences and interactions can be narrated and then examined; thus, personal stories about experiences have often been targeted by narrative studies. Narratives offer a way of ordering experiences and constituting reality (Bruner, 1991) or 'some fundamental way of making sense of experience' (Garro & Mattingly, 2000, p. 10) for the narrators themselves. According to Riessman, 'narrative analysis refers to a family of methods for interpreting texts that have in common a storied form' (2008, p. 10). She typified NA into the following four categories—thematic, structural, dialogic/performance, and visual (p. 19). We adopted dialogic/performative NA for our study, which elucidates the narrative content and how, when, and why the given narratives were interactively produced (p. 105). In this dialogic/performative NA, the descriptions of the narratives conveyed the involvement of the researchers during interactions and the analysis focused on the structures, contents, and contexts of narratives and the manner of narration (pp. 105–107). As the narratives were collaboratively constructed between an interviewer and an interviewee (Ellis, 2011; Mishler, 1991; Riessman, 2008; Yamada, 2007), the interviewer (the first author, MM) reflected upon her own illness experience as a physician as well as upon previous interviewees' experiences to enhance each of the interviews. The narratives of all interviewees were transcribed verbatim in Japanese and verbatim quotations were translated into English following the analysis.

Participants

For the interviews, we recruited 18 Japanese doctors who had experienced becoming patients. Purposive sampling, designed to augment the researchers' understanding of the

research candidates and to aid the development of theories, was adopted for this study. Through such sampling, ‘information-rich’ cases, including individuals, groups, sites, and/or behaviours, are selected as they can ‘provide the greatest insights into the research question’ (Devers & Frankel, 2000, p. 264). Prospective participants were recruited via a mailing list of doctors interested in medical education, invitations by the authors through casual conversations with medical colleagues, or research proposal presentations at academic conferences for physicians. Consequently, the participants enrolled in this study were interested in narrating their own experiences as patients, thereby contributing to medical education research. As patients’ experiences were private and confidential, participants who accepted an invitation from the first author (MM) were prioritised, and only those who agreed to be interviewed participated in this study. To ensure confidentiality of the participants’ identities and experiences, the interviews were conducted either in person in a private space or via Skype. The duration of the interviews lasted between 1 and 2.5 h. As doctors who have published illness narratives are assumed to have strong opinions regarding this aspect of medicine or the tendency to recapitulate what they have previously written, we recruited participants who had never published their illness experiences.

From 2018–2019, data was collected from 18 participants (14 men and four women) from diverse specialities and aged between 20 and 60 years. Each participant shared their experience of being ill, and how it influenced their practice. Of the 18 participants, nine were general practitioners/internists, while the remainder practised cardiology, dermatology, ophthalmology, paediatrics, palliative care, respiratory medicine, and surgery. Moreover, seven participants previously taught or currently teach undergraduate medical education. Two authors of this study had similar backgrounds to the participants: MM is a general practitioner and was a PhD student at a medical education centre at the time of conducting the interviews; HN is a general internist and medical educator. The participants’ conditions varied, ranging from benign ailments to malignant diseases, and included both acute and chronic illnesses. All participants were given pseudonyms. Certain diseases were changed in the final report for the protection of participant privacy.

Narrative construction

To understand the participants’ transition—from doctors to patients and back to doctors, we considered each question as a platform for a plot and eventual acquisition of the complete story; this is known as ‘emplotment’ (Mattingly, 1994). Anthropologist Cheryl Mattingly (1994) suggests that discourse or performance can be interpreted through texts, and that people involved in these acts can construct a complete story as if they were developing plots (emplotting) in the text. In an ethnographic study focusing on how occupational therapists provide care to patients, Mattingly reported that therapists effectively used their words and acts to emplot a story for patients looking towards recovery (Mattingly, 1994). Interviewer MM attempted to construct a plot within a story wherein the interviewees experienced the doctors’ world first, then the patients’ world, and then returned to the doctors’ world again. This emplotment could situate the interviewees in different ‘worlds’ and lead them to narrate their stories chronologically. With the progression of the participants’ narratives, tensions in their transitions were recognised, followed by the emergence of self-awareness.

For the analysis, we reconstructed brief stories following the plot that we used for conducting the interviews. This process of reconstructing raw interview data into a story for NA is based on Mishler’s method of narrative case studies (Mishler, 1999; Petty et al.,

2018). Mishler proposed that the cases should ‘retain temporal patterning of events such as the sequence of narrative episodes’ (1999, p. 25). Hence, the researchers reconstructed raw interview data into chronologically or thematically coherent stories (Kim, 2016, p. 213; Mishler, 1999, p. 25; Petty et al., 2018). The raw data and brief stories were repeatedly read and analysed thematically by MM. Following Riesman’s dialogic/performative NA, the focus was on when and how the interviewees narrated their stories and how the interviewer responded to them. The results of the analysis were repeatedly triangulated between the author and the co-authors of the study.

Reflexivity

The first author, MM, had experienced being a patient after becoming a physician. This illness experience inspired her interest in the experiences of other doctors as patients. The plot that MM tried to construct during each interview aligned with the doctors’ experiences and resonated with MM’s own. In the initial stages of the interviews, MM found that the interviewees talked to her about their disease in medical terms, as if they were her colleagues. Therefore, each interview started by situating the interviewer and the interviewees in the doctors’ world, by discussing how interviewees found out about having their respective diseases using medical terms. MM gradually invited interviewees to the patients’ world, talking about their stories as patients. In this stage, MM intended to shift from medical terms to colloquial expressions. MM intentionally narrated her own illness experience to interviewees, which might have helped interviewees to revisit their experiences as a patient. Each interview enabled MM to compare her experience with that of the interviewees. While accumulating data, MM could compare the interviewees’ narratives, which helped her recognise the diversities and similarities in each experience.

During the interpretation and writing of this study, MM used her experience as a reference. HN provided his insights and interpretations of doctors’ experiences as patients, which helped MM to be open to the illness narratives that were different from hers. JI contributed by interpreting MM’s patient experience as a process of entering a different community, that is, into a patient’s world from a doctor’s world and then returning to her community as a doctor, just as an anthropologist does in anthropological research, which influenced the narrative constructions during the plotment of this study.

Results

All participants reported that their illnesses had impacted their medical practice. Given the contexts of the narratives, the point in time when they narrated their experiences could have influenced their interactions with their patients. Thus, we argue that the influence of a doctor’s experience of illness changes with time. Taking into consideration the time gap between the interviews and the doctor’s illness, three different narratives were chosen as contrasting cases to illustrate how doctors’ experiences as patients could differently influence their medical practice. The first two narratives were recounted within five years after the illness. The third one was narrated more than ten years after illness onset. The three narratives aligned with the other 15 narratives in terms of doctor-patient interactions, but differed in the degree of familiarity with patienthood and the possibility of sharing their experiences with patients. Although most of them mentioned changes to their psychological distance from their patients, one of the interviewees stated that he was feeling closer

to the technologies and the medical professionals that he was surrounded with during his hospitalisation; this greatly influenced his subsequent medical practice. As our focus was on empathy in the interactions between doctors and patients after the doctors experienced being patients themselves, the narrative of this interviewee did not represent our focus.

When we described the three narratives, we also considered the effect of distance from illness (psychological distance and the duration of time after illness) and its effect on the doctor–patient interactions.

Time of co-construction of the narratives

All the participants reported that their illness had impacted their medical practice. The influence of a doctor's experience of illness changes with time. If a shorter duration of time had passed (less than five years) after the illness, the participants described feeling closer to their patients. They also had a better understanding of a patient's experience, familiarising themselves with the medical technology and facilities from the patient's perspective. One of the participants reported that he felt hostility towards his patient's husband, who apparently did not sympathise with the patient suffering from the same disease as the participant. The participant identified with the patient; he reported that for a while after the illness, he wanted to share his diagnosis with his patients, but this impulse gradually diminished and finally disappeared.

With time (i.e. after five years), the participants found that the memories of their experiences had faded. They felt distant from the sensations and emotions that they experienced during their illness; however, they could vividly recall the words spoken to them and certain events that affected them deeply. The passage of time could lead to changes in perspectives. While examining the impact of a traumatic event, Miyaji (2007, pp. 5–18) found that narrators' perspectives changed with time and resulted in psychological distance from the illness. Some were unable to narrate their experiences, especially if enough time had not passed or if there was not enough psychological distance from the experience (Frank, 2013, pp. 97–100; Miyaji, 2007, pp. 5–18). Not only the story but the duration and circumstances under which the story is narrated, and the distance that narrators feel from the experiences are also important. This was reflected in the narratives gathered in this study.

Influences of doctors' illness on their medical practice

In the first narrative of a general internist, Dr Suda recounted the experiences of 'shared sufferings with patients'. His narrative suggested that an embodied and shared nature of empathy could emerge from interactions with patients while also recognising that patients' circumstances were sometimes beyond the sphere of his empathy.

The second narrative showed that illness experiences can increase the emotional distance between a doctor and a patient rather than enhancing their proximity. Dermatologist Dr Makino felt that his suffering exceeded that of his patients while he waited for his surgery. His attention was directed towards himself, thus distancing him from his patients. This is different from the narrative account of Dr Suda and contradicted the typical nature of a doctor's illness narrative, in which the doctor's empathy towards their patients increased.

Finally, we discuss the case of Dr Yokota, who intentionally used his illness experience as a tool to strengthen the doctor-patient relationship. The possibility of using 'illness as a tool' suggested in this narrative was similar to those of others who had experienced their

illness more (rather than less) than five years prior to the interviews. Although they differed, all narratives revealed the possibility for creative expression stemming from doctors' illness, such as the ability to understand patients' perspectives.

Shared illnesses between doctors and patients

Dr Suda, who was in his thirties, worked in a general hospital. Approximately two years before the interview, he had developed cervical neuropathy because of a herniated disc. Upon noticing his symptoms, he obtained evaluations and medical advice through informal consultations with his peers. In a way, Dr Suda was his own doctor and patient, diagnosing himself, investigating his symptoms, and receiving expert input through corridor consultations. At the beginning of the interview, Dr Suda and MM talked about his disease as if they were talking about a patient for presentation in a medical ward. To elucidate Dr Suda's experience of patienthood, MM asked him about the extent to which the disease occupied his mind. Dr Suda replied:

It is not zero at all; it is always there. I mean, if I rated how much it occupies my mind from 0 to 100, it is 1 or 2 when there are no symptoms. However, once I sense a symptom, it abruptly rises to as much as 50.

Once Dr Suda understood how anxiety was amplified by a minor symptom, he reported that his attitude towards his patients' anxieties transformed:

Recently, I began placing importance on what the patients suffer from and what they worry about, especially the latter; that is, I feel that focusing on the patients' worries should be emphasised along with what I can do. This thought emerged gradually and did not just pop up after the diagnosis of my herniated disc. I am now aware of situations in which I sometimes feel anxious because of my disease. Therefore, I have begun focusing on what the patients worry about when they have chronic diseases that are sometimes possibly exacerbated.

Dr Suda went on to report that he had gained considerable knowledge of herniated discs and had begun to feel a sense of familiarity with patients with the same or similar symptoms.

I can acknowledge what patients tell me when they have a herniated disc. Talking to them, I feel as if I belong to a group of herniated disc patients rather than being involved in a doctor-patient relationship. I mean that in those moments, I felt as if I were a co-patient. Sometimes, I disclosed my own experiences when I met a patient with the same disease or symptoms that I had.

Dr Suda developed the ability to immerse himself into his patients' inner worlds, and his disclosure of his illness experiences signalled his proximity to them. By sharing his sufferings and experiences, he developed a better sense of camaraderie with patients. Conversely, he realised that he could not completely understand the feelings of patients suffering from terminal illnesses, as he had not experienced terminal illness himself. He stated:

As a medical professional, I try to understand how a patient with terminal lung cancer or COPD (chronic obstructive pulmonary disease) feels when they tell me about experiencing nausea. However, I find it impossible to understand their feelings and sensations in the truest sense. I mean that I cannot understand them from the depth of my heart, and that I cannot respond to them in a manner that comes naturally to me.

The doctor thought about ‘a genuine understanding of suffering’, which was rooted in his experience of seeing a simulated patient when he was a medical student:

When I was a medical student, I embraced the fact that I could not completely understand a patient’s sensations and feelings. For example, seeing a simulated patient with pain because of a clavicle fracture at the medical school, we, the students, usually told them that we could understand how painful the condition was for them. However, I felt that we did not truly understand the patient’s sensations. Nevertheless, if one has experienced a clavicle fracture, it is valid to say that they would be able to understand the pain of a patient undergoing the same experience.

He narrated how impossible it was to understand symptoms and situations that he had not experienced and how superficial the phrase, ‘I know how you feel’ was. He felt that the phrase was merely what every student was taught to say to a simulated patient in medical school.

Thus, Dr Suda’s narrative of ‘shared illnesses between doctors and patients’ can reveal several ranges of empathy that have been discussed in previous literature across multiple disciplines. Empathy can differ according to the degree of involvement and understanding, with or without shared sensations and emotions; simply telling patients, ‘I know how you feel’, is mimetic. Trying to understand patients’ sensations and feelings is cognitive and interpretive, whereas sharing experiences can be embodied and experiential. While sharing his suffering, Dr Suda blurred the boundary between his patients and himself; thus, he experienced his proximity to patients. Narratives from other participants can resonate with Dr Suda’s narrative in terms of empathy during doctors’ interactions with patients. They remembered their own sensations, anxiety, and discomfort, and felt close to the patients with diseases and situations like theirs.

Increased distance between a doctor and a patient

The second narrative is that of Dr Makino, a male dermatologist in his forties who had a soft tissue malignant tumour. He had discovered the tumour himself several years before diagnosis but ignored it, believing that the tumour was benign. When he decided to visit a doctor, the tumour had grown and was suspected to be malignant. Dr Makino was surprised to be informed by his doctor about his MRI results revealing a tumour so large that malignancy could not be disregarded. Thereafter, he was referred to a plastic surgeon at the hospital in which he had been working for a year. As his disease was dealt with by professionals in his own field of specialisation—dermatology—or by plastic surgeons, he was aware of the treatment for the tumour and did not seek information about it or consult others, unlike the other interviewees. He read the reports of his MRI and PET scans independently and understood the necessity for extensive surgery to remove the large tumour. During the series of examinations and imaging that followed, he continued to work as usual. He described his medical history to MM as if he were a specialist discussing a disease impassively with a medical colleague. He disclosed his feelings while waiting for his surgery as a patient, as follows:

Since I was told that I should be admitted to a hospital for surgery, I was nervous and had butterflies in my stomach. The result of the PET scan frightened me because it showed the possibility of metastasis of the tumour. In the end, there was no metastasis, even though the tumour was probably malignant. Although I was

relieved to hear that there was no metastasis, I knew that the scan could not precisely reveal the stage of the tumour and other lesions.

MM asked him if he remembered his patients who had suffered from malignant tumours. He answered:

I have seen patients with malignant skin tumours, some with the same kind of tumour as mine. However, I did not project my feelings on them when I was diagnosed with the disease. I was just really shocked to know that my tumour was malignant. That was more shocking than I had expected.

Dr Makino reported how he was affected by his illness during the days before the surgery:

My work in the outpatient clinic was so difficult for me because the clinic is a place where patients discuss their skin ailments with a doctor. I was unable to listen to their troubles. So, during those days, I felt it was too difficult for me to continue working as a doctor and listen to patients. On the day before my admission, I even refused to meet a patient who was referred to me by a doctor working in the same clinic. I thought that I would be unable to bear the situation of meeting the patient. I could not accept patients' complaints because their problems were less severe than mine.

Dr Makino's disease required extensive surgery, which took almost an entire day. The removal of his tumour was successful, and a PET scan revealed that there was no recurrence, which relieved him. MM asked about the changes Dr Makino had observed after the surgery, to which he responded:

I may have shifted my priority to my family rather than to my work as a doctor. I do not want to become stressed about anything related to my work because I am uncertain whether the cancer cells were completely removed from my body, and I am afraid of my disease returning. In my work, I sometimes see patients with malignant tumours and inform them about their diseases. Earlier, I did not understand what they went through, but my experience has made me realise what it is like to be a patient. When I encounter a patient in a situation similar to mine, I can imagine ways in which they could be having a hard time.

Dr Makino's thoughts about his patients were different before and after the surgery. Before the surgery, his suffering was so overwhelming that it left no room for accommodating others' problems. As he reported, his patients' troubles were too minor compared with his malignant tumour, which isolated him from his patients.

After Dr Makino's tumour was completely removed and the PET scan revealed no recurrence, he recounted that he had begun imagining how a patient with cancer would feel, though this was not accompanied by self-disclosure of his illness to his patients. He referred to this act by using the verb 'imagine' and not 'sympathise' or 'empathise'.

He lived as a patient before and after the surgery; he has been living as a survivor, fearing recurrence. Therefore, as Miyaji (2007) pointed out in the trauma studies, Dr Makino could not narrate his experiences in front of his patients or involve his experience in his medical practice as explicitly as Dr Suda. The phenomenological aspects of empathy that we raised in the introduction do not apply to his narrative because Dr Makino's attention and intentions were focused on his body and not on his patients. However, after returning to work, he began to imagine how cancer patients would feel

based on his experience, which made him closer to the patients. Thereupon, he could regain his position as a doctor paying attention to his patients.

Shared illness experiences do not necessarily invoke empathy in a doctor or enhance empathetic medical practice, as Dr Suda narrated. The psychological distance between a doctor and their patients may increase rather than decrease when the doctor is still a patient and recognises a disparity in the severity of their illness compared to that of their patients. Another doctor who had slight pain owing to an orthopaedic disease narrated how he thought that a patient with the same disease had described their symptoms as being excessive. Thus, he started doubting the severity of the patient's pain. If there is a gap between a doctor's illness and a patient's, it could invoke a response denying the patient's experiences, as opposed to an empathic response.

Illness as a means

Dr Yokota, a male palliative care doctor in his sixties, suffered a car accident and was severely injured 15 years prior to this study. He suffers from serious complications because of his injuries, with visual (diplopia), motor, and sensory impairments. After graduating from medical school in his twenties, Dr Yokota began working as a surgeon. About 20 years later, he switched his speciality from surgery to home care medicine (known as 'house calls' in Western countries). His car accident occurred on his way back to the hospital after he had witnessed his patient pass away at home. During the interview, Dr Yokota had a memo on which he had meticulously written his medical history. His memories of the accident were unclear, and his wife informed MM that he had been unconscious for nearly two weeks and neurologically compromised for two months after the accident. Owing to the brain damage and orthopaedic injuries, he needed to have intense rehabilitation after awakening.

MM asked Dr Yokota how he felt about his symptoms when he first recognised them. He answered:

I was not astonished by my symptoms (diplopia, motor disabilities, and abnormal sensations in extremities) because I knew that there were three cerebral contusions, and I understood what they were. I just hoped that my diplopia would improve, but it has not. As for walking, I was afraid that I would not be able to move without a wheelchair at first, but eventually, I could even walk without a cane, although climbing stairs required some effort. I do not think the degree of my disability will become more severe.

Six months after the accident, Dr Yokota began working at the hospital again. He had to change his place of work several times and finally settled down as a doctor in a palliative care unit. He told MM that he used to worry about his artificial graft becoming infected for nearly three years after the surgery. However, time passed, and so did his fears.

MM asked Dr Yokota about the effects of his suffering and complications on his medical practice, to which he responded:

I think my attitude towards my practice has not changed after the accident because I have been interested in and pondered upon death, dying, and palliative care for a long time. Instead, I used my experience of being a patient to care for my own patients. For example, I told my patients that I had to use a ureteral catheter for a while. What I told them was meaningful to them. They knew that I had the same experience as

them, so I was able to understand their condition. I even share with them my thoughts from when I was bedridden.

Contrary to the previous two narratives, Dr Yokota narrated his illness experience as if he was detached from it, never mentioning his emotions. MM asked him about when and how he decided to disclose his experience to patients, to which he answered:

I do not tell every patient about my experience of illness. Sometimes, I feel that it is the right time to talk about it, and at other times, it is not. I know when it is the right time. In addition to my own stories, I have also collected stories of interactions between my patients and myself. I record each episode in the form of an essay, and if I feel that it is necessary, I distribute the recording to my patients.

Dr Yokota treated his own and his patients' illness experiences like a tool to care for other patients. He noted that sharing his illness experience or the collected stories from his past patients encouraged patients to share their own feelings and thoughts or to talk about symptoms in common, such as diplopia. His disclosure was thus a gesture through which he conveyed his understanding, consequently strengthening the relationship between himself and his patients.

However, he has never shared his experience of nearly dying with his patients. In the interview, he articulated his perception of the moment of death. MM asked him the reason.

For about six months after the accident, I kept thinking that my life might have ended in the accident. My memories of immediately before and after the accident were gone, and my life could have just ended. The thought that my life could have ended suddenly made me wonder how subtle life's ending is. Death is like that, a sudden and simple thing. One cannot be totally prepared for death. Dying and death happen in a short moment, and the last moment can occur at any time in one's life.

After seeing patients being admitted to a palliative care unit, Dr Yokota imagined how they might perceive their dying process. Although he has his own perception of death and dying, he has never talked to his patients about it owing to the following reason:

I think that my notion about the moment of death is not certain and is too simple. I do not believe that sharing it with my patients would be beneficial to them. That is why I never talk to them about it. Moreover, I am still pondering upon the meaning of death and dying and do not have a definitive answer. This is another reason I do not share my notion.

Dr Yokota's way of handling his experiences was different from those of the previous two doctors. He narrated that he could consciously reconcile patients' experiences with his own and share only a part of his experience if needed. Dr Yokota's disclosure of his symptoms may be interpreted as merely exercising the skills required to share similar hardships, as reflected in Dr Suda's narrative. However, Dr Yokota's narrative was not accompanied by a reflection on his feelings, unlike Dr Suda, who was aware of his anxiety. In this sense, Dr Yokota did not experience the embodied nature of empathy, which was termed as 'genuine empathy' by Dr Suda. Additionally, the other participants whose illnesses were distant enough from the time when the interviews were conducted mentioned that their fearful emotions receded as time passed. They utilised their illness experiences to show that they understood their patients and to feel close to them. This seems similar to mimetic empathy, as in the example of a hunter wearing moose skin to get closer to a moose. However, their own illness experiences were buried underneath the superficial outlook. It is possible that

their illness led to a new awareness that was helpful in their practice; this process, however, took a long time and could not have been taught formally.

Discussion

The three narratives illustrated how the doctors' first hand experiences as patients influenced their medical practices differently with time. In addition, they differed in terms of the degree of familiarity with, and the psychological distance from patienthood, as well as with their possibility of sharing experiences with patients.

The first narrative by Dr Suda revealed how difficult it was to separate cognitive and emotional empathy (sympathy) and to disassociate the sensations and emotions perceived during the illness from the practice of medicine. A spectrum of empathy—from superficial and mimetic to embodied and experiential—was also reflected in his narrative. Dr Suda's experience as a patient led to 'genuine understanding', which supports the belief that a doctor's illness can enhance their understanding of the patients' illness and suffering.

Unlike Dr Suda, Dr Makino's experience distanced him from his patients. As Charon (2006) noted, witnessing suffering is necessary for doctors. However, this notion may require doctors to witness both the patients' suffering and their own. When illness experiences are used as a tool to develop empathy, doctors tend to overlook their own suffering; the transition from finding an illness distressing to being able to understand patients may necessitate the passage of time and psychological distance from the experience. However, Dr Makino's narrative shows that a gap between a doctor's illness and the patient's problem could widen the distance, thus inducing a response in the doctor that is contrary to empathy.

Dr Yokota's tendency towards self-disclosure in front of his patients could be considered a skill, but it evolved from his suffering—unlike Dr Suda's disclosure, Dr Yokota's disclosure was not accompanied by his anxiety or distress because his suffering had been mitigated with time and emotional distance. Moreover, he intentionally utilised a part of his illness and applied it to his patients' needs. His narrative indicates that the sufficient passage of time and psychological distance from illness may be necessary for a physician suffering from illness to become a 'wounded healer', that is, someone who uses their wisdom gained from the experience of illness for patient care.

Deconstructing empathy in clinical contexts

Corresponding to the discussion above, research in clinical contexts and medical education has emphasised the cognitive nature of empathy (Hojat, 2016); however, several researchers (Garden, 2007; Halpern, 2001; Hooker, 2015; Macnaughton, 2009; Pedersen, 2009) have argued that the idea of empathy as embodied in phenomenological traditions cannot be disregarded; this study supports the latter argument.

Moreover, the doctors' illness narratives in this study illustrated the broad spectrum of empathy in clinical contexts, which can be used to deconstruct the concept of empathy. For example, the range of empathy reported by Dr Suda can be categorised into already recognised types of empathy, ranging from mimetic and superficial empathy to embodied and experiential empathy.

Considering that the narrators' responses were based on their interactions with their patients, doctors can play the function of being 'receptacles' of patients' mental and

physical anguish. (Charon, 2006). In this sense, empathy in clinical contexts can be conceptualised as a 'response' to patients' sufferings. Such a response may range from passively 'identifying with' or becoming actively involved with the patients, to becoming closer to patients by disclosing information on their past sufferings.

Based on the perspective that 'doctors are receptacles of suffering', we can infer that doctors' disclosure or awareness of their illness in response to patients' suffering may cause the doctors to reflect on their own suffering. Some doctors like Dr Suda might perceive patients as peers sharing their afflictions, whereas others may not be able to tolerate their patients' suffering either because they feel their own personal suffering more severely than that of their patients or because their afflictions are so close in the psychological distance that they cannot narrate it to others. Some doctors, like Dr Makino, need some time before they can overcome their illness and respond to their patients' needs.

Thus, based on the narratives in this study, we found that 'empathy'—defined in various ways in different clinical contexts—cannot be reduced to cognitive or emotional empathy alone. As a clinical competency, empathy can be developed over time. This resonates with Hooker's (2015) critique from a phenomenological standpoint. Through the doctors' narratives, we understand that 'empathy' is contextual, complicated, and entangled with the professional work and illnesses of doctors. In addition, it depends on when interaction with the patients occurs, and how the doctor associates their own illnesses with those of their patients.

Doctors' illness experiences in medical education

One of the sources from which empathy can emerge are doctors' experiences of illness. This context has been found to be a useful pedagogical tool, so much so that medical education regards doctors' illness narratives as model cases for teaching empathy to students and subsequently improving patient care. (Hahn, 1996; Klitzman, 2008; Murakami and Hinohara, 2003; Onji, 1989). Doctors who have experienced being patients often perceive their duties as including advocacy for improving medical practice and the health care system (Hahn, 1996; Klitzman, 2008; Murakami and Hinohara, 2003; Onji, 1989).

In agreement with previous research (Fox et al., 2009; Hahn, 1996; Klitzman, 2008; Morishita et al., 2020), this study revealed that illnesses in physicians can encourage them to reflect on the nature of illness, providing them with an opportunity to develop their understanding of their patients' perspectives and situations. We agree that doctors' illness experiences can be a means of increasing their understanding of patients' needs. In addition, the doctors' illness narratives in this study also highlighted the various complexities of their illness experiences and the spectrum of empathy that can emerge in their clinical practice, which has not been explored in previous studies. The narrators also suffered from illness and re-encountered their suffering during their interactions with the patients, which was unexplored by typical discourse and previous papers that studied doctors' experiences as patients.

Yamashita (2014) discussed the suffering of Japanese general internists ensued from their medical practice and noted that their suffering was marginalised and overlooked as a function of their profession. They were supposed to act professionally and prevent their emotions from interfering with their work. While professional behaviour is essential, these ideals can dehumanise doctors by ignoring their suffering (Yamashita, 2014). The dehumanisation of doctors occurs when doctors' illnesses are regarded merely as a way of nurturing empathetic skills and fodder for medical education. Thus, exploring

doctors' experiences as patients enabled us to appreciate their humanity and the fact that they experience the same emotions and physical discomfort as their patients do. This could aid in expanding medical students' and doctors' awareness of their vulnerabilities and allow them to explore the meaning of suffering for themselves and others, the attitudes they have towards suffering and the disabilities arising from the suffering. Moreover, they could realise the effects of surrounding factors, medical culture, and importantly, themselves as medical professionals. In addition, awareness of their vulnerabilities would allow them to explore how they could achieve well-being. Therefore, we argue that the narratives of doctors' illness experiences could help medical students and doctors to deepen reflections on how they could care for other people, considering their own well-being.

Reconsidering the wounded healer

So far, we have discussed empathy in clinical contexts and how we can situate doctors' illnesses in medical education through the analysis of their narratives. To conclude, we have focused on the transformation of illness over time, as reflected in the narratives in this study, through which we have elucidated further areas of interest pertaining to the relationship between doctors' illness and empathy.

Previous studies on doctors becoming patients have evoked the adage, 'doctors should always be healthy' (Edelstein et al., 1984; Klitzman, 2008; Mandell and Spiro, 1987), an attitude that may cause doctors to, once they become patients, feel alienated from the medical community. As noted above, some scholars have instead focused on the concept of the 'wounded healer' to depict doctors who gained wisdom and/or increased their empathy towards patients, through experiencing a period of illness. These doctors have tried to restore a sense of meaning to doctors regarding their illness (Hahn, 1996; Klitzman, 2008; Ukigaya, 2014), and thereby showed the possibilities for overcoming suffering.

The narratives in this study revealed how doctors' suffering affected their practice and promoted their understanding of patients' hardships. On the one hand, doctors' first-hand experiences with illness were found to strengthen the doctor–patient relationship, as shown in previous studies; on the other hand, these experiences may have distanced the doctor from their patients. Additionally, the narratives showed that gaining sufficient time and distance from experiences might be necessary to generate wisdom for medical practice and that some doctors may require a long period to recover. It remains unclear how doctors can transform their experiences as sources of suffering into sources of wisdom, including the capacity to empathise.

In medical education, the learning process to become a doctor is akin to an apprenticeship. However, professional and ethical codes generally prohibit a 'therapeutic' trainer–trainee relationship in medicine (Reitz et al., 2013), unlike the therapeutic relationship between a master and an apprentice in ethnomedicine (Ukigaya, 2014). In addition, the scientific approach of Western medicine has long portrayed doctors as healers and patients as healed objects (Foucault, 2003; Shinmura, 2016), which may lead to the externalisation and objectification of doctors by members of their own community when they become patients.

In this study, Dr Suda reported feeling as if he belonged to the patients' circle, as their peer when he met a patient with the same disease. Thus, meeting such patients or joining a community of patients may be a healing experience for doctors.

Limitations and recommendations for further study

This study has some limitations. First, the plot we used in the interviews—from doctors' to patients' and back to the doctors' world—enabled the interviewees to narrate and reflect on their experiences with illness and responses in each world. The emplotment could have created a boundary among stories from two different standpoints—of the doctor and that of the patient. However, doing so could have limited the scope of narratives of the illness experiences and, consequently, overlooked the transitional states between the two worlds. Significant aspects, such as the embarrassment and difficulty experienced by doctors who emerged from the dual roles of doctor and patient (noted by previous research Hahn, 1996; Klitzman, 2008), would have been excluded. Even though we established boundaries while examining the narratives in each world, medical terms and channels of thought (such as medical processes, including diagnosis, examination, and treatment) tended to remain in the narratives. This may have been because the influence of the interviewer MM, a medical doctor, could not be removed, and the participants' identities as doctors were strong.

Another limitation of the study pertains to the participants. As the participants of this study were people interested and involved in medical education, they might have tended to think about the utility of their illness experiences and knowledge for educational purposes. Furthermore, they had gained enough psychological distance to narrate their illness experiences. It is unknown what the doctors think about their interactions with patients after their illnesses, when the psychological distances from their experiences are too short and they were unable to narrate their experiences to others.

Moreover, we did not interview patients. Therefore, their perception of doctors sharing their illness experiences with them is unknown. Some of the patients might see doctors sharing their illness experiences as a marker of empathy, whereas this might not be the case for other patients.

Future studies could explore the transformational processes of nature, meaning, and narrativisation of doctors' illness along with their lives as a whole. This study could not elaborate on transformational process of doctors' illness or the interaction between doctors and their surrounding communities after an illness. Further study is required to enhance our understanding of how doctors' 'empathy' is cultivated in medicine and to explore how this can be implemented in medical education.

The communities they become part of, as a consequence of their illness, may be key to understanding these processes. In addition, as the descriptions of the socio-cultural and historical contexts of the participants were omitted from this article, their illness experiences within the clinical contexts were not sufficiently analysed. Future studies, in which narratives are analysed within these contexts, can reveal how Japanese medical culture and society affect doctors' illnesses. These studies might also help doctors and medical students understand and nurture 'empathy' in medical education.

Conclusion

This study examined the effects of doctors' illnesses on their medical practices, especially on doctor-patient interactions. This investigation allowed us to go beyond the simplistic reflection around these experiences, according to which once doctors become patients, they can understand their patients better.

To this end, we reviewed the literature on empathy in medicine and other disciplines; then, we clarified our perspective on empathy, emphasising its validity as a clinical tool and its phenomenological aspects. We selected three out of 18 stories relating to Japanese doctors' illnesses to elucidate how they narrated their interactions with patients after having experienced illnesses themselves. The three narratives showed that 'empathy' can have various meanings, such as memetic, phenomenological, and instrumental, which facilitates its deconstruction and reflects the complex and contextual nature of this concept.

The results showed that the distance between the doctors and their patients shrunk if the doctor experienced a recent illness—as observed in previous studies. However, doctors may be unable to bear patients' problems when they experience illnesses of greater severity. Thus, we conclude that to transform a suffering experience into wisdom and to include 'empathy' as a clinical tool (that is, to become a healer who gains wisdom from their suffering), sufficient time and distance from illness are needed.

Additionally, the narratives showed that emphasising the educational utility of doctors' illness may have disregarded their suffering. Doctors' illness can expand their awareness of vulnerability and enable them to reflect on how people care for others.

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The ethics approval for this research (R-1235) was granted by the Ethics Committee of the Graduate School and Faculty of Medicine, Kyoto University.

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