

Empathy in Nursing: A Phenomenological Intervention

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Abstract: *Today, many philosophers write on topics of contemporary interest, such as emerging technologies, scientific advancements, or major political events. However, many of these reflections, while philosophically valuable, fail to contribute to those who may benefit the most from them. In this article, we discuss our own experience of engaging with nursing researchers and practicing nurses. By drawing on the field of philosophical phenomenology, we intervene in a longstanding debate over the meaning of “empathy” in nursing, which has important implications for nursing research, training, and practice. However, our intention is not only to introduce and discuss this philosophical intervention. Rather, we present this intervention as a model for how philosophers might successfully engage with the field of nursing, and perhaps with other fields as well, with the aim of effecting positive change in research or practice. The article proceeds in five parts. First, we introduce the problem of conceptual clarity in nursing and explain why many nursing concepts are still in need of refinement. Second, we discuss the origins of the concept of empathy in nursing and outline the challenges associated with borrowing theory from other fields. Third, we explain how nurses tend to conceptualize empathy today, drawing upon the psychological distinction between cognitive and emotional empathy. Fourth, we discuss our intervention in this debate and explain how we attempt to resolve existing conceptual confusions by developing the concept of empathy from the ground up. Fifth, we conclude by briefly reflecting upon some of the challenges of interdisciplinary engagement and providing some recommendations based upon our own experience.*

Introduction

Today, many philosophers write on topics of contemporary interest, such as emerging technologies, scientific advancements, or major political events. However, many of these reflections, while philosophically valuable, fail to contribute to those who may benefit the most from them. In some cases, this is simply because the philosophical

work is published in a venue that it not widely read by people outside of philosophy, including those involved in the events or practices discussed in the work. In other cases, the work itself is written in an inaccessible manner, perhaps because of unfamiliar jargon, the style of argumentation, or an overreliance on broad abstractions rather than concrete examples.

Philosophers should, of course, have the freedom to develop ideas and engage in debates that may be of interest only to those already embedded in their field of research. But many philosophers who write on contemporary issues do aspire to have an impact upon the world outside of philosophy and even the world outside of academia. How one's work can have this kind of impact is, however, a challenging question. Traditional philosophical training tends not to focus, for instance, on the challenges of engaging in genuinely interdisciplinary research, much less on the challenges of effectively engaging with people outside of academia.

In this article, we discuss our own experience of engaging with nursing researchers and practicing nurses. By drawing on the field of philosophical phenomenology, we intervene in a longstanding debate over the meaning of "empathy" in nursing, which has important implications for nursing research, training, and practice. However, our intention is not only to introduce and discuss this philosophical intervention. Rather, we present this intervention as a model for how philosophers might successfully engage with the field of nursing, and perhaps with other fields as well, with the aim of effecting positive change in research or practice.

The article proceeds in five parts. First, we introduce the problem of conceptual clarity in nursing and explain why many nursing concepts are still in need of refinement. Second, we discuss the origins of the concept of empathy in nursing and outline the challenges associated with borrowing theory from other fields. Third, we explain how nurses tend to conceptualize empathy today, drawing upon the psychological distinction between cognitive and emotional empathy. Fourth, we discuss our intervention in this debate and explain how we attempt to resolve existing conceptual confusions by developing the concept of empathy from the ground up. Fifth, we conclude by briefly reflecting upon some of the challenges of interdisciplinary engagement and providing some recommendations based upon our own experience.

1. The Problem of Conceptual Clarity in Nursing

Before intervening in an existing conceptual debate, it is essential to familiarize oneself with the history of the field, including how the field's conceptual frameworks originated and how they are used today. Without this knowledge, it is impossible to determine whether or how a philosophical concept might be of value to the field in question.

Modern nursing, understood as the professional practice of caring for those who are ill, has a history dating back to the 1800s. However, nursing as an academic discipline has a considerably shorter history, with university departments of nursing first created in the 1960s. As a new research field, nursing had to quickly establish its disciplinary identity. It wasn't immediately clear, however, where exactly nursing fit within the broader university structure. Initially, it might seem that nursing stands squarely within the fields of biomedical research. However, the concerns that dominated the profession of nursing differed in key respects from the concerns of, for instance, biology or organic chemistry. Nursing researchers were fundamentally concerned with what it meant to be a nurse and how to effectively interact with and care for their patients. As Mark Risjord explains, already "In the 1940s and 1950s, nursing education had supplemented the physician's biological knowledge with psychology and sociology. Nursing knowledge had thus grown beyond the boundaries of medical knowledge, but there was, as yet, little that nurses could call their own" (Risjord 2010, 15). In the decades that followed, nurses sought to establish a distinct theoretical foundation for their own discipline. However, at least in the initial stages, nurses still aimed to model their research on traditional approaches in the sciences. Dorothy Johnson (1959) and Rozella Schlotfeld (1960), for instance, argued that nursing as a research field should be able to develop its theoretical foundations independently of nursing as a practice. As a result, nursing research was not understood as a mere response to practical issues in the field. Rather, it was free to establish its own aims, which would in turn shape and influence nursing as a practice (Risjord 2010, 15). In opposition to this view, several nursing scholars argued that nursing practice should be the primary guide to research. Because practicing nurses are experts in their own right, they are capable of identifying practical problems that researchers should further investigate and attempt to resolve (Risjord 2010, 15–16).

Despite this initial pushback, nursing scholarship, for the most part, continued to prioritize theory over practice. In the 1970s and 80s, however, an increasing number of nursing scholars expressed their frustrations with the fact that nursing theory failed to provide any concrete guidance for nursing practice (see, e.g., Hardy 1978; Miller 1985). They argued that a relevance gap had emerged between

theory and practice. Jean Watson (1981) as well as Janice Swanson and Carole Chenitz (1982) argued that this gap emerged because nursing continued to model itself on the quantitative approaches of the natural sciences, which failed to resonate with the everyday practices of nursing (Risjord 2010, 28). They suggested that nursing should instead draw upon the qualitative approaches pioneered in the social sciences. While the social sciences had already had some influence on the theoretical foundations of nursing, this new focus on qualitative methods pushed nursing further in this direction.¹

This turn toward the social sciences certainly increased the relevance of nursing research for nursing practice. However, some nursing scholars also questioned whether nursing should be borrowing theoretical foundations from other disciplines in the first place. Would it not be better for nurses to develop their own theoretical foundations from scratch—theoretical foundations that were tailor-made to the field of nursing?

One of the main motivations for this move is that the longstanding practice of borrowing theories from other disciplines produced what we might call conceptual heterogeneity. As Janice Morse and her colleagues explain, early phases of a new scientific field, such as nursing, are often ripe with conceptual confusion. On the one hand, “similar theoretical explanations often compete for preferred acceptance, while allied concepts vie to account for the same phenomenon”, producing a situation in which different concepts are used with similar and overlapping meanings (Morse et al. 1996, 254). On the other hand, “one concept may have several definitions; and in some cases, these various meanings may be implicit, unrecognized by researchers and clinicians, resulting in a lack of clarity that makes nursing a soft science—or at least softer than is desirable” (Morse et al. 1996, 254). This lack of conceptual clarity undermines scientific research, including the potential for such research to effectively guide or influence practice.

In response to these conceptual confusions, a considerable amount of intellectual labor has been devoted to adapting, refining, and applying concepts to the field of nursing. This intellectual work is typically achieved through what nurses call “concept analysis” (which differs from the philosophical approach called “conceptual analysis”). Nurses employ a variety of methods for concept analysis. Regardless of the method, however, the primary aim is to bring a concept to “maturity”. An immature concept is one that is poorly defined, often because the boundaries of the

¹ For a more detailed overview of the history of nursing as a science, see Risjord (2010 Chs. 1 and 2).

concept have not been adequately articulated, resulting in substantial overlap with other concepts. Through various methods of analysis, researchers attempt to develop and delineate a concept, ideally to a point where it is measurable or can be reliably used in scientific studies or in clinical practice. In some cases, this is achieved by constructing a model case to which the concept can be legitimately applied, then reviewing apparently related or otherwise illegitimate cases that help refine the meaning of the concept.² Other approaches rely on extensive analyses of how the concept has been used in the existing literature. And still others may examine how the concept is used in measurement tools or in clinical applications, or even how practitioners describe the concept in qualitative interviews.

Concept analysis was especially popular in the 1980s and 90s. Throughout this period, we find analyses of key concepts that are central to the nursing profession, such as caring, coping, dignity, empathy, grief, health, hope, privacy, and suffering. Most of these concepts were borrowed from other disciplines and then, in some cases, modified or adapted for use in nursing. Morse and her colleagues argue, however, that many of these analyses were overly simplistic. The descriptions and definitions produced by various methods of concept analysis did little to advance nursing knowledge (Morse et al. 1996, 225). In our opinion, these analyses often provide an excellent overview of the diversity of definitions associated with what at first appeared to be a coherent concept. But few of these analyses manage to develop or refine the concepts in a meaningful and lasting way.

2. The Origins of Empathy in Nursing

After this general overview of how nursing's concepts originated and developed, we are now able to identify a key concept in nursing that might benefit from philosophical clarification. Because of its central and longstanding role in the field of nursing, we have decided to focus on the concept of empathy as a potential target.

Nurses, by and large, agree that empathy is key to effective nursing practice. But, even today, there's no consensus on how to define it. The term is used in a variety of ways in the nursing literature, referring to a range of perceptual, cognitive, affective, and behavioral phenomena. As used within this literature, the concept often overlaps with related terms, such as sympathy, care, or compassion. Because of this lack of

² For more detailed accounts of this approach, which are called Wilsonian or Wilson-derived methods, see Wilson (1963), Walker and Avant (2018), and Rodgers (2000).

consensus, empathy, as used within nursing, remains an immature or partially developed concept.

Like most concepts in nursing, empathy was originally borrowed from other disciplines. One of the original influences on nursing's conceptualization of empathy came from Carl Rogers' work on therapeutic empathy. Rogers, a well-known psychotherapist, was invited to give the keynote address at the American Nurses Association in 1957. In his address, he introduced his concept of therapeutic empathy, which he initially defined in an overly simplistic way: "To sense the client's world as if it were your own, but without ever losing the 'as if' quality—this is empathy" (Rogers 1957, 99). However, he soon elaborated the concept as follows:

The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain hitherto as if one were the person, but without ever losing the 'as if' condition. Thus it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is *as if* I were hurt or pleased and so forth. If this 'as if' quality is lost, then the state is one of identification. (Rogers 1959, 3:210–11)

Here, we see Rogers specify his concept of empathy in a bit more detail and begin to differentiate it from related concepts—in this case, the concept of identification. Over his career, Rogers reworked his concept of empathy and, at times, became critical of his early definitions. However, it was his early conceptualization that initially had a major influence on nursing.

Despite the initial positive uptake of Rogers' work, some nursing scholars eventually became critical of his concept of empathy, in part because it originated in an outside discipline. Morse and her colleagues, for example, argued that Rogers' concept of therapeutic empathy was specifically developed to help understand the relationship between a psychotherapist and her client. This kind of relationship differs in important respects from the relationship that a nurse is supposed to develop with her patient. For instance, while it's important for the nurse to understand a patient's experience, such as how they feel about a recent diagnosis or an upcoming procedure, she may not need to develop the kind of rapport that facilitates a successful psychotherapeutic intervention. Considering this, Morse and her colleagues recommended that nurses devote more energy to developing their own unique

theoretical foundations and concepts, rather than borrowing concepts from other disciplines that are often an imperfect fit for nursing:

Nursing as a profession is perhaps more unique than we have previously recognized, and this uniqueness has both advantages and disadvantages. One of the disadvantages is that we must develop our own practice (including our own interventions) cautiously and wisely rather than mimicking the therapeutic strategies of other professions. Conversely, the development of unique nursing theory and practical knowledge must be considered an advantage and essential as we develop as a distinct discipline. (Morse et al. 1992, 279)

Borrowing theory from other disciplines may appear to be a productive shortcut to establishing the conceptual foundations of a new field. However, such adaptations come with the risk that the theory or its concepts simply aren't a good fit, either because they refer to an irrelevant phenomenon or because they characterize this phenomenon in an unproductive way.

We think that Morse and her colleagues' concern is germane, but that it needs to be qualified. Not all disciplines develop their concepts in the same way. When nurses adapted Rogers' concept of therapeutic empathy, they took the concept from another applied discipline: psychotherapy. Because Rogers developed his concept with the aim of better understanding the relationship between psychotherapist and client, he didn't necessarily intend his conceptualization of empathy to be broadly generalizable. If his concept of therapeutic empathy functions well in other disciplines, this is, in a sense, accidental.

But this problem holds only for applied disciplines. Consider, for instance, the concepts developed in philosophy or theoretical psychology. Concepts developed in these more theoretical disciplines tend to be generalizable. The psychological concept of short-term memory, for instance, isn't intended to clarify what it's like for a particular kind of person to remember (e.g., what it's like for a waiter to remember an order). Rather, the concept is meant to identify a general feature of human experience, which is characteristic of all human beings. These fields often develop concepts that are meant to help us better understand general aspects of human existence, rather than particular issues or situations that apply only to some subset of the population.

Considering this, nursing scholars have at least two conceptual strategies: (1) Develop concepts from scratch that consider the distinctive or even unique aspects of nursing; (2) adapt broadly generalizable concepts from more theoretical disciplines.

3. Empathy in Nursing Today

By and large, it seems that nursing scholars have opted for the second strategy. Most concepts in nursing are still adapted from other fields. But today these concepts tend to be derived from theoretical rather than applied fields. We consider this to be a positive development. But adapting concepts from theoretical fields has its own risks that we need to consider. There is certainly less reason to be concerned over whether these concepts will apply to a particular field since they are intended to be broadly generalizable. However, one needs to be certain that the generalizable concept accurately characterizes the phenomenon that it is intended to help us understand. If the concept mischaracterizes the phenomenon, then it may provide an inadequate or misleading foundation when adapted by more applied disciplines.

This is precisely our concern with the concept of empathy as used in contemporary nursing. Today, nursing scholars tend to rely on a key conceptual distinction that they borrowed from psychology. This is the distinction between cognitive and emotional empathy. Cognitive empathy is defined as the ability to understand the other's experience through higher-level intellectual processes, such as imaginative perspective taking, critical thinking, or inference. In the nursing literature, it's sometimes referred to as "state" or "clinical" empathy (although these terms are sometimes used with a slightly different meaning). This concept of empathy has received particular attention in the literature on nurse education since it is often assumed that cognitive empathy is a learned skill that can be trained or developed.

This is contrasted with emotional empathy, which is typically characterized as the innate capacity to understand the other by sharing their emotional experience. Some nurse scholars suggest that this kind of empathy might also be trained (e.g., Alligood and May 2000), but this is a minority position. However, the inability to train emotional empathy is not the main reason that nurses typically appeal more to cognitive than to emotional empathy. The primary concern is that, if emotional empathy produces understanding only by sharing the other's feelings, then this may eventually become overwhelming in the clinical setting and lead to burnout. The

emotional toll, for instance, of understanding a patient's distress by taking on the feeling yourself may outweigh any benefits.

This criticism of emotional empathy extends beyond the field of nursing. The psychologist Paul Bloom argues that, in the field of health care, patients want to be treated by clinicians who understand them through cognitive empathy but aren't overwhelmed by emotional empathy. He says,

As I write this, an older relative of mine who has cancer is going back and forth to hospitals and rehabilitation centers. I've watched him interact with doctors and learned what he thinks of them. He values doctors who take the time to listen to him and develop an understanding of his situation; he benefits from this sort of cognitive empathy. But emotional empathy is more complicated. He gets the most from doctors who *don't* feel as he does, who are calm when he is anxious, confident when he is uncertain. (Bloom 2014)

Considering the opposition to emotional empathy in nursing and psychology, it may seem that the conceptual confusion that plagued the nursing literature throughout the 1980s and 90s is largely resolved: Emotional empathy should be avoided in nursing practice whereas cognitive empathy should be trained and developed so that nurses can better understand and care for their patients.

In our view, however, the distinction between cognitive and emotional empathy rests on a misunderstanding about how we initially come to know or understand another person. It is certainly the case that we can cognitively understand another by using techniques such as imaginative perspective taking. And there might be cases where feeling as someone else feels helps us better understand them. However, both cognitive and emotional empathy rely on a more fundamental empathic capacity, which has been articulated in considerable detail by philosophical phenomenologists.

4. A Philosophical Intervention

How do we come to know and understand others in face-to-face encounters? On the proposal currently under consideration, either by using intellectual processes that rely on imagination, reason, and inference, or by affectively sharing the other's mental states. If, however, we turn to phenomenologists such as Edmund Husserl, Edith Stein,

and Max Scheler, who were among the first to develop a proper philosophical account of empathy at the beginning of the 20th century, they all offer a different answer. On their view, empathy at its most basic—in the following called *basic empathy*—is a perceptually based form of interpersonal understanding, one that more complex and indirect forms presuppose and rely on. This is why they often used the term “empathy” interchangeably with terms such as “other-experience” or even “other-perception” (Husserl [1931] 1960; Scheler [1923] 2008). As Scheler famously writes,

[W]e certainly believe ourselves to be directly acquainted with another person’s joy in his laughter, with his sorrow and pain in his tears, with his shame in his blushing, with his entreaty in his outstretched hands, with his love in his look of affection, with his rage in the gnashing of his teeth, with his threats in the clenching of his fist, and with the tenor of his thoughts in the sound of his words. If anyone tells me that this is not ‘perception’, for it cannot be so, in view of the fact that a perception is simply a ‘complex of physical sensations’, and that there is certainly no sensation of another person’s mind nor any stimulus from such a source, I would beg him to turn aside from such questionable theories and address himself to the phenomenological facts. (Scheler [1923] 2008, 260)

On their view, one can obtain an acquaintance with the other’s experiential life in the empathic face-to-face encounter that is direct and immediate (Fernandez and Zahavi 2020b).

Here is a concrete example: If you notice a patient suddenly tense her muscles and start hyperventilating when you are about to give her an injection, you immediately perceive the patient as being afraid of the needle. Under normal circumstances, you don’t need to infer such experience from the precise configuration of the other’s facial muscles, posture, or breathing pattern, nor do you need to engage in some elaborate process of imaginative perspective taking where you attempt to put yourself in the patient’s shoes to conclude that she must be afraid. At the same time, you didn’t need to share her fear of the needle to perceive the patient’s fear. Rather, we simply perceive bodily movements and gestures as expressive of desires, intentions, emotions, attitudes, and so on. It’s only in cases where we perceive the meaning of someone’s expressive behavior as ambiguous, or we otherwise have some reason to doubt our immediate understanding, that we turn to other cognitive or emotional techniques for making sense of others. Empathy, according to the

phenomenologists, gives us the experiencing other directly, non-inferentially, as present here and now (Stein [1917] 1989, 7). But there will always and by necessity remain a difference between that which I am aware of when I empathize with the other and that which the other is experiencing. Empathy is consequently *not* about me having the same mental state, feeling, sensation, or embodied response as another, but rather about me being experientially acquainted with an experience that is *not* my own. Empathy targets foreign experiences without eliminating their otherness. In empathy, I am confronted with the presence of an experience that I am not living through myself. To empathically grasp another's fear is not to be fearful oneself, but to recognize the joy as belonging to the other. This is why phenomenologists have standardly rejected proposals according to which empathy should entail that the other's experience is literally transmitted to me or require me to undergo the same kind of experience that I observe in the other. Following on our example above, when I perceive the patient as afraid, I perceive the fear *in her*. I may, in reaction to her subjective state, become afraid, surprised, or concerned; but it's not my feeling that provides me with an understanding of the other. We only feel the way that we do because we already understand the other as being in a particular state.

In reply to claims made by both Bloom and some nursing researchers (e.g., Morse et al. 1992) that empathy can hinder clinical care because the sharing of the patient's affective states might be overwhelming and lead to burnout, one might consequently argue that the very identification of empathy with affective sharing is based on a misunderstanding. This, at least, would be the view of the phenomenologists. Empathy, correctly understood, is an immediate, intuitive perception of the other's mental state, which does not require that one share this state. Nurses should not, therefore, be wary of relying on this kind of intuitive empathic understanding.

Providing an alternative conceptualization of empathy is, however, only the first stage in our philosophical intervention. As we mentioned above, one of the challenges of borrowing concepts from more theoretical disciplines is that it may not be immediately apparent how they can be usefully applied to a new field. This is certainly the case with the concept of basic empathy. If empathy is as basic as the phenomenologists claim, isn't it then something that nurses not only already use in their daily interactions with colleagues, patients, and family members, but also something so fundamental and automatic that it is entirely outside of their control? If a nurse cannot help but experience his patient through basic empathy, then why do we need to say anything about it at all?

We argue that empathy might be direct, immediate, and automatic, but is still something that can be obstructed or facilitated in a variety of ways. And it is precisely this possibility of obstructing basic empathy that nurses should be concerned with in their clinical practice. Consider again the fact that we can employ different strategies when trying to understand others. To take a concrete example, imagine a situation where you must care for a patient who has become paralyzed as a result of a traffic accident. To offer proper care, you need some understanding of how the patient is coping with his new life-situation. How can you obtain that understanding? One option is to draw on theoretical knowledge. Being deprived of your mobility is likely to limit your ability to satisfy your wants and desires and will also force you to reassess your life goals, all of which is likely to decrease your quality of life and make you distressed if not depressed. Another possibility is to use your imagination and attempt to put oneself in the other's position. By imagining what it would be like for me to be paralyzed, I might come to appreciate what it must be like for you. But to seek to understand the other on the basis of prior theoretical knowledge or by imaginative perspective taking risks violating or doing away with the other's perspective altogether. Imaginative perspective taking, in particular, risks being an imposition of one's own view upon the other; it might in the end be nothing but an attempt to constitute the other through projection and fantasy. This danger is well illustrated by what has become known as the *disability paradox* (Albrecht and Devlieger 1999). Although external observers often judge individuals with serious and persistent disabilities to live an undesirable or even miserable life, when asked, those very individuals often report that they experience a good or excellent quality of life. Against this background, the clinical relevance of basic empathy, or of what might be termed empathic openness, should be obvious.

Perhaps some might object to this and argue that the only way we can truly understand others is by having (or by having had) the same kind of experiences that they do. To truly understand what it is like for a woman to give birth, for example, one must have given birth oneself. But is that always an advantage? Imagine having had an easy birth, and then witnessing a woman who is in a lot of pain because of a difficult birth. Will the fact that one has given birth oneself necessarily make one more appreciative of her experiences, or might it on the contrary make it more difficult to grasp what it is like for her, since one might be inclined to generalize from one's own case and therefore assume that it is probably not as hard as it seems? None of this is to deny that imagining what it must be like for the other, i.e., engaging in imaginative perspective taking, might occasionally help one appreciate someone else's experience.

But the imaginative exercise supplements the more basic understanding of them that you already achieved through your empathic perception. More comprehensive accounts of both classical and contemporary phenomenological analyses of empathy can be found in Husserl ([1931] 1960), Scheler ([1923] 2008), Stein ([1917] 1989), and Zahavi (2010; 2011; 2014; 2017; 2019). But, for now, let us emphasize that the direct and immediate character of basic empathy doesn't entail any claim regarding its infallibility. Basic empathy is fallible. Indeed, just as you can be mistaken about an object that you perceive, you can be mistaken about a person that you empathize with. In the case of misperception, it wouldn't be right to say that you didn't have a perception at all. Rather, you simply had an inaccurate perception, which is likely to be corrected by other perceptions that you have of the same object. In much the same way, you can have an inaccurate empathic understanding of the other, which may be corrected as you continue to engage with them.

In light of this understanding of basic empathy—including both its immediate access to the other and its potential for fallibility—what actions might a nurse take if she finds herself unable to accurately understand her patient? Rather than, for instance, trying to imagine her way into the patient's perspective, she might instead solicit the patient's self-narrative, asking questions that prompt the patient to provide more detail or explain their experience in a new way. As a form of encounter that preserves and respects the other's otherness, basic empathy lets the clinician approach the other with the requisite attitude of humility; there is still much that they do not understand. A central task of the nurse is not to imagine what it must be like to be the patient, but to attend to and help the patient find a voice of their own, where they can express and articulate their point of view.

5. Reflections on Applied Phenomenology

What should one take away from this philosophical intervention? How might other philosophers successfully intervene in debates in other fields, including fields that are fundamentally oriented toward various kinds of practice? While there are certainly aspects of our philosophical intervention that are unique to the field of nursing and the debates that we engaged in, we would like to close by reflecting on some of the more generalizable aspects of our approach.

First, one should consider how each discipline has obtained and refined its key concepts. In our case, this task was not as difficult as it might be when engaging

with other disciplines. Nursing, as a field of academic research, has a relatively short history, so it is comparatively easy to identify when concepts entered the field and where they originated from. Other fields, especially those with considerably longer histories, may pose a greater challenge. One may, for instance, need to turn to the history of ideas to identify the origin and development of a key concept in a scientific field. While this kind of work may seem needlessly laborious when one's aim is to engage in a contemporary debate, we believe that understanding how and why particular concepts came into use is key to developing an effective philosophical intervention. Without knowing where these concepts came from and why they were needed, one risks repeating problems that may have been addressed in the history of the field. In our case, it was helpful to find that nurses had become wary of borrowing concepts from other disciplines due to a concern about a lack of fit. This motivated us to clarify the differences between borrowing concepts from applied fields and from theoretical fields, which was key to supporting our integration of philosophical concepts into nursing.

Second, one should consider how a discipline uses its concepts in practice. Concepts that are integral to research aren't always used in the same way by practitioners. If one attempts to effect change in practice by engaging only with how concepts are used in research, the intervention is less likely to succeed. In the case of nursing, for instance, the relevance gap gave us reason to be skeptical about whether the empathy debates in nursing scholarship had any effect on how practicing nurses engaged with their patients. However, we found that the literature on empathy education and training in nursing largely echoed the concerns expressed in the scholarly debates. Some articles, for instance, stressed that the ongoing conceptual confusion over the meaning of empathy in nursing was a major obstacle to the design, implementation, and evaluation of empathy training in nursing programs (see, e.g., Brunero, Lamont, and Coates 2010; Williams and Stickley 2010). This gave us reason to believe that further clarifying the meaning of empathy might have positive effects on training and practice (Fernandez and Zahavi 2020a).

Third, and finally, one should demonstrate how abstract concepts can be applied by using concrete examples. As we explained above, theoretical and philosophical concepts should, in principle, be generalizable. In practice, however, it is not always apparent how such concepts apply to a particular domain. One doesn't necessarily need to provide overly detailed examples to illustrate the applicability of a concept. Even relatively simple examples can go a long way toward demonstrating such applicability, so long as they resonate with the audience and help them see how

the concept gears into the relevant context. In our case, we demonstrated how the phenomenological concept of basic empathy and empathic openness assuages concerns associated with emotional empathy (i.e., that the clinician might become overwhelmed by the patient's feelings) and avoids shortcomings associated with cognitive empathy (i.e., that the clinician may project their own experiences on to the patient). By providing clear examples of how empathic openness may facilitate engagements between clinicians and patients in clinical encounters, we offer a starting point for both nursing scholars and practicing nurses to further explore how they might put such a concept to use.

Philosophy is often characterized as one of the most abstract academic disciplines, with little relevance to everyday life or concrete practices. Since its inception, however, phenomenology has been a source of inspiration for empirical science and the world beyond academic philosophy. Its non-philosophical relevance has been part of its enduring appeal and arguably also what has made it so attractive to many different disciplines, including that of nursing (Zahavi 2020; Zahavi and Martiny 2019). In recent years, however, philosophers from many different traditions have become increasingly interested in contemporary issues across a variety of topics and fields. To make sure that our intellectual labor does not go to waste, we should continue to reflect on how philosophy can engage in relations of mutual enlightenment with other disciplines and practices.

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