Empathic Interruptions of the Clinical Wish

Archive, Interruption, Expansion

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Alden March Medical Student Ethics Conference, 2026

BACKGROUND & ARCHIVE

The clinical wish

In the early 2000s, scripted "I wish" statements emerged in medical communication literature as way to break bad news and to manage difficult emotion, unrealistic hope, and disappointment in the clinic. This was a response to multiple simultaneous pressures:

- Legal and ethical demands for disclosure and informed consent
- Moral demands for empathic patient-centered care
- Institutional demands for teachable, measurable clinical skills
- Physician and trainee anxiety about the delivery of bad news

The prototypes for these *clinical wishes* were the "SPIKES" protocol (Baile et al. 2000) and Quill, Arnold & Platt's "I Wish Things Were Different" (2001). The influence of these papers, and the concepts of *wish* and *empathy* they illustrate, reveal an *archive of the clinical wish* that functions notably through *dramatic* scripts.

> *Doctor: I'm sorry that the x-ray shows that the chemotherapy doesn't seem to be working [pause]. Unfortunately, the tumor has grown somewhat.*
>
> *Patient: I've been afraid of this! [Cries]*
>
> *Doctor: [Moves his chair closer, offers the patient a tissue, and pauses.] I know that this isn't what you wanted to hear. I wish the news were better.*
>
> — Walter Baile et al. (2000)

Within the archive of the clinical wish, three aspects of *wishing* can be found that, together, distinguish the wish from other clinical utterances:

Suspension of clinical role

Non-sovereignty over limits

Scriptability & reproducibility

Across clinical communication literature, "I wish" statements proliferate as a paradigmatic empathic utterance, one that can is spoken in the clinic proper, and expected in an assessment setting (OSCEs, Step 2 CS, etc.):

I wish things were different

I wish we could do more and that medicine had better answers

I wish there were something we could do to cure your illness

I wish we had more effective treatment for your illness

I wish I had some other kind of news

I wish we had been able to do more

I worry that you might die from this sooner than either of us had wished

I wish I could promise you that

I wish I could give you a simple formula for how to proceed

I wish there was something else I could do

INTERRUPTIONS

I
EMPATHY INTERRUPTS THE CLINICAL SCENE

The clinical wish interrupts the properly clinical encounter, suspending the physician's instrumental role and clinical judgement, opening space for solidarity and nonabandonement.

II
THE FETISH INTERRUPTS THE INTERRUPTION

As a subject of capitalist forms of affective labor, the empathic function of the wish inhabits the character of an inverted commodity-fetish, concealing structural conditions behind the veil of care.

III
GESTURE INTERRUPTS THE FETISH

Redeployed as Brechtian *gestus*, the wish becomes an estranging act that reveals rather than resolves its contradictions, against the closers of empathic sentimentality.

Models of clinical empathy

Tripartite clinical empathy
The tripartite model is implicit in the archive: (1) *cognitive capacity* to name the patient's emotion, (2) *experiential resonance* or *similitude,* and (3) *communicated expression*. Empathy is both felt and performed. And while the communicated, performative element that the clinical wish is designed to deliver, a "performativity" of all three emerges. (Okon 2006, Butler 1988)

Engaged clinical empathy
This model, popularized by Jodi Halpern, exceeds "detached concern" without collapsing into ordinary feeling-into. Empathy is an act of attunement and associative reasoning — not vicarious experience, not daydream. The physician resonates with the patient's emotions without being moved by them. Crucially, clinical empathy is meant to facilitate better *clinical, medical judgement* and decisions. (Halpern 2003)

Positive feedback loop
Some empathic scripts work with an interactional model of empathy as a "circuit" or "feedback loop." For example, Coulehan et al. construct scripts consisting of *queries, clarifications* and *responses* that move an encounter toward an empathic consensus. (Coulehan et al. 2001, Frankel 2017)

> *"We may lay it down that a happy person never fantasies, only an unsatisfied one. The motive forces of fantasies are unsatisfied wishes, and every single fantasy is the fulfillment of a wish, a correction of unsatisfying reality."*
>
> — Sigmund Freud, "Creative Writers and Day-Dreaming" (1959)

Situating the wish in the optative "as-if"

Freud: The wish (*Wunsch*) names a process irreducible to intention or desire. A wish can be fulfilled without action and without belief in the actual obtainment of its object, even in the face of known impossibility. Wishing does not negotiate the conditions for action but instead opts for fantasizing about the wish-fulfillment situation, which is satisfying enough. (Pataki 2014, Boothe 2004)

Kant: The "mere wish" (müßige Wünsche) sits at the threshold between simple affect and judgment, a representation accompanied by pleasure or displeasure, indifferent to the practicality of its object. This pleasure and the desire to announce it allows the wish to function as an appropriation of the form of aesthetic judgements of taste: *formal purposiveness, disinterest, and universal validity or communicability.* (Kant 2013, Englert 2017)

EXPANSIONS

Theoretical expansions: wishing

Expansion 1: Suspension → Aesthesis
Rancière: The Kantian aesthetic regime introduces "dissensual" preconditions for the suspension of ordinary hierarchies of sensing and sense-making, moments in which the usual assignment of bodies and senses to functions is interrupted. The clinical wish performs exactly this: a physician's "I wish" suspends the instrumental logic of the clinical encounter, introducing what Adorno calls "freedom to the object" — the capacity to apprehend the patient's situation as meaningful rather than merely functional. (Rancière 2010, Adorno 2017)

> *"Divorcing the fleeting gaze from the labouring arms introduces the body of a worker into a new configuration of the sensible, overturning the 'proper' relationship between what a body 'can' do and what it cannot."*
>
> — Jacques Ranciere , *Dissensus* (2017)

Expansion 2: Non-Sovereignty → The Sublime
Adorno: The dynamically sublime discloses a contradictory structure: the subject encounters its own powerlessness, yet discovers within itself a capacity for resistance not reducible to mere existence: "a "pictureless picture of utopia." The cognitive and affective work of fantasy and the coming to terms with experiences of the sublime allow for the imagination of novel ethical and political relation, and makes though non-transparent, affect-laden and anticipatory. (Adorno 2017, Khan 2016, Dyčková 2023)

Expansion 3: Scripting → Sociality
Laplanche and Pontalis: Fantasy is not a private interior image but a *mise-en-scène*, a scenario with assigned roles, structured like a script; and triangulates with wish and sublimation, all three of which are scaffolded by an image of the "other." (Laplanche & Pontalis 1988; Al-Kassim 2010

Arendt: The wish, as judgement, is inherently social appeal to a s*ensus communis,* organized around the demand that one's being be acknowledged within a shared symbolic order. And inasmuch as this speech is social, it is also pleasurable/affectively charged (Arendt 1992; Ngai 2020)

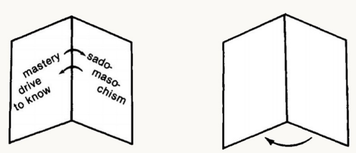

Figure. Laplanche's sublimatory decahedron (1999)

EXPANSIONS

Theoretical expansions: empathy

Expansion 4: Habitus
Through simulation, rehearsal and repetition, clinical empathy becomes professional *habitus*, an affective practice that reshapes the body's capacity to feel, for the purpose of confidence, naturalism and spontaneity. Simulation specifically breeds an empathic clinical habitus that "need not feel real" to be experienced as authentic. (Underman 2015)

Expansion 5: Labor
Situating formal empathy training within the corporatization and commercialization of American healthcare, patient satisfaction becomes a monetizable outcome. Hence, the scripts of empathy become as much about risk management and labor-as-commodity, as they are about intimacy, relation and solidarity. (Vinson & Underman 2020, Farris 2025)

Expansion 6: Fetish
The extension of the clinical wish's scripts to structural concerts, eg. patient financial hardships, makes a claim of equivalence. This functions as a co-optation of even authentic displays of empathy towards effective structural concealment in vein of commodity-fetishism. This ultimately interrupts the normative (even radical) promise of the clinical wish. (Farris 2025; Hardee, Platt & Kasper, 2005)

> *Patient: Doc, are you sure I have to go to the hospital and get intravenous antibiotics? I have a 500-dollar copay when I am admitted and even though I feel terrible, I'd rather just go home and take my chances.*
>
> *Physician: I understand that it costs more for hospital care. I wish there was a less expensive alternative in terms of treating your pneumonia. However, given the severity of the x-ray findings, I really don't think that sending you home with oral antibiotics is a safe option.*
>
> — James Hardee, Frederic Platt & Irene Kasper (2005)

The wish as gesture

Brecht's epic theater of *gest* and *A-effect* makes familiar social relations appear strange, contradictory and irresolvable, against the trance of empathic identification. A wish held as gesture is an "interdicted action" that interrupts the scene before protocol reasserts control, making the conditions that make wishing necessary strange enough to feel transformable. (Brecht 1977, Butler 2017, Benjamin, 1998)

> *"Epic theatre does not reproduce conditions; it discloses, it uncovers them. This uncovering is effected by interrupting the dramatic processes; but such interruption does not act as a stimulant; it has an organizing function."*
>
> — Walter Benjamin, "Author as Producer" (1998)

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Acknowledgments: Dr. Angela Scott & Dept. of Medical Humanities & Bioethics, UAMS. The Bruce and Brandon Lee Medical Scholarship.