



Empathy and shame through critical phenomenology: The limits and possibilities of affective work and the case of COVID-19 vaccinations

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Abstract

This paper begins by developing the critical phenomenologies of shame and empathy. It rejects that empathy is the supposed antidote to shame, and rather demonstrates the ways in which they function in parallel. The author contends that both shame and indeed empathy risk objectifying and fetishizing the other who is being shamed or empathized with. This argument and phenomenology about the relationship between shame and empathy is then applied and further developed through a case study of COVID-19 vaccinations. The author explores whether empathy and shame ever “work” to increase vaccine uptake, and ultimately argues that both affects do and do not depending on the structures of power informing the specific context.

KEYWORDS

Covid-19, empathy, Phenomenology, shame

Organizing works. Activism works. Shaming works.
#PeoplesVaccine

– Naomi Klein on Twitter, 3:07 PM EST, 5 May 2021¹

There are numerous studying [sic] confirming that shaming does NOT work and that empathy and listening to concerns actually has the highest conversion vaccination rates. Shame is a tool of oppression—it will never be a tool for social justice (or public health).

– Brené Brown on Twitter, 3:57 PM EST, 5 May 2021²

On 5 May 2021, the US government announced that it would support a proposal to waive patent protections for the COVID-19 vaccine. Naomi Klein, a prominent Canadian-American political activist and author, retweeted the announcement by White House news reporter Jenny Leonard and added her own commentary: ‘Organizing works. Activism works. Shaming works. #PeoplesVaccine’.¹ Less than an hour after Klein’s tweet, Brené Brown, a popular

American social work professor and author known for her work on emotions and vulnerability, replied with criticism of Klein’s statement that shame works. Brown wrote: ‘There are numerous studying [sic] confirming that shaming does NOT work and that empathy and listening to concerns actually has the highest conversion vaccination rates. Shame is a tool of oppression—it will never be a tool for social justice (or public health)’.² A debate followed in the replies to both tweets, with many clarifying to Brown that she misunderstood Klein’s original tweet: Klein was not writing about shaming individuals who are vaccine hesitant, but rather shaming a government who fails to put public and global health above private profits. Regardless of this misunderstanding, Brown and her supporters doubled down on their stance that shame does not ‘work’ in any context and is not justified for any reason, regardless of whether it is directed at individuals or institutions.

These tweets raise critical questions about the varied and vexed ways in which shame ‘works’ in healthcare: what does and can it do, and for whom? To begin answering these questions, I’m turning to Luna Dolezal and Sarah Ahmed’s critical phenomenologies in their respective books *The Body and Shame* (2016)³ and *Strange Encounter*

(2000),⁴ as well as Ahmed's affect theory in *The Cultural Politics of Emotion* (2004).⁵ By critical phenomenology, I mean a methodology that 'deals with not just the experience of reality itself, but the social, political, and cultural milieu in which these experiences occur'.⁶ That is, I seek to understand shame and empathy not just as experiences in-and-of-themselves, but as shaped by and shaping a broader social, political, and cultural milieu. The first half of this article will explore the phenomenologies of shame and empathy, and the second half will explore that theory through the case of COVID-19 vaccinations.

To begin: what is shame? Shame can refer to the act of shaming, like the example cited above with Klein and Brown, and/or the experience of feeling shame. I state 'and/or' because shaming does not necessarily result in the other actually feeling ashamed, but the following discussion will focus on the case of shaming resulting in felt shame. Such shame is experienced as both intimately personal feeling, and on the other hand, a highly social and even political emotion. Dolezal theorizes that while felt shame is 'an intensely personal and individual experience, body shame only finds its full articulation in the presence (actual or imagined) of others within a rule and norm governed sociocultural and political milieu. As such, it bridges our personal, individual and embodied experience with the social and political world which contains us'.³ Similarly, Ahmed⁵ theorizes that while felt shame often pulls the self away from others (think: averted eyes, literally turning away from others), the subject of shame takes in the view (think: feelings and judgements) of how they appear to real or imagined others, thereby seeing themselves as if they actually are what the other perceives. Ahmed thus alerts us to how felt shame is fundamentally an experience of double exposure: 'On the one hand, shame covers that which is exposed (we turn away, we lower our face, we avert our gaze), while on the other, shame exposes that which has been covered (it un-covers)'.⁵ Dolezal also emphasizes how 'body shame involves exposure and the "seen body"; one is seen by oneself or by others (whose views and judgements one shares) to be "doing wrong" or to be failing or flawed in some crucial way'.³ These views and judgements shared by the shamed subject do not just come from the one who shames, but rather a broader system of socially, culturally, and even politically constructed norms that are transgressed or failed to be met by the shamed other. This is the critical analysis Ahmed and Dolezal bring to the phenomenology of shame—that shame is not merely produced in an abstract encounter between the 'I' and a real or imagined other, but rather entangled in wider cultural, social, and political systems like sexism, racism, ableism. Dolezal goes on to theorize that 'shame can only find its full articulation within a normative framework, more than an encounter between two bodies is needed. Instead, a whole complex world of language, culture and normative values must be in place, where certain behaviours, actions or modes of being are prohibited and seen as deviant and others are socially sanctioned and considered "normal" or "acceptable"'.³ Ahmed⁵ would similarly describe such an experience of shame as the 'affective cost of not following the scripts of normative experience'.

Another window into felt shame's phenomenology is by exploring shame's relationship to its supposed opposite: empathy.

This thematic issue is on shame and respect, but when I think of respecting another's views, actions, or person, I think ultimately of striving to understand where another is coming from—hence I end up at empathy. Or, to be more precise, I end up at the popular colloquial understanding of empathy as fellow feeling through stepping into the feelings and perspectives of another, as marketed by popular figures like Brené Brown.⁷ Returning to the initial tweet I quoted by Brown, she posits empathy not only as the antithesis of shame, but even its antidote: shame does not work, she asserts, but empathy does. In doing so, she implies the relationship between shame and empathy as opposites: the shaming subject judges and pushes away a shamed other, meanwhile the empathizing subject understands and moves close to others. This reflects a broader discourse on how empathy can be a cure for everything wrong in healthcare. Here's one example: medicine's paternalism and even shaming of patients can supposedly be cured if doctors are just trained to be more empathetic of their patients. This kind of empathy is often 'trained' often through patient 'expert' panels, communication skills workshops, reflective writing, and even reading literature in groups.^{8–10} Here's another example: healthcare worker burnout can supposedly be prevented and even cured if healthcare workers find ways to reconnect to the deep meaning and relationships that are central to their work by, for example, using techniques like reflective writing to preserve empathy.¹¹

This kind of empathy work has been critiqued by numerous scholars in the medical humanities, including Anne Whitehead and Angela Woods as they make the case to push the field forward in ways that are critical to the empathizing impulse of the 'first wave' of medical humanities.¹² Rebecca Garden does precisely that in her seminal essay 'On the Problem of Empathy', wherein she argues: 'Theories of empathy must address tendencies to objectify the patient as a spectacle of suffering through which physicians exercise their own virtue [...] Further, theories of empathy that emphasize interpersonal relations should not obscure the larger social contexts that determine illness and disability, beginning with inequities in access to and quality of health care based on ethnicity, class, gender and sexual/affective orientation'.¹³ I too seek to problematize empathy, but through its relationship to shame. To reveal the ways in which shame and empathy may actually function in parallel, I will move from the colloquial understanding of empathy as fellow feeling back to empathy's phenomenological roots as an 'other-directed form of intentionality' that 'allows the other's experiences to disclose themselves as other'.¹⁴ I understand empathy-as fellow-feeling to be a narrowed view of empathy's broader phenomenological structure. Thinking critically about empathy's broader structure, especially through Ahmed's work, will better help us see the fallacy of empathy-as-cure by revealing how empathy's phenomenology, like shame, can also risk othering, objectification, and fetishization that abstracts the other from its social contexts.

Parts of empathy's phenomenological structure is surprisingly similar to felt shame—albeit with some critical differences that help further nuance the phenomenology of both empathy and shame. Ahmed theorizes: 'Shame requires an identification with the other



who, as witness, returns the subject to itself. The view of this other is the view that I have taken on in relation to myself; I see myself *as if I were this other*.⁵ In other words, the shamed self takes in the view of real or imagined others' feelings, perspectives (often judgements of that other), and experiences, re-shaping themselves through the lens of that other. Similarly, the empathizing self takes in the view of real or imagined others' feelings, judgements, and experiences (or at the very least tries to) and re-shapes themselves through the lens of that other. The first critical difference between the phenomenologies of shame and empathy I am describing is that the 'I' or 'self' of shame is the object of the action of shaming where the shaming actually results in felt shame. That is: I am describing the phenomenology of shame from the perspective of one who is shamed, rather than the one who is shaming. The 'I' or 'self' of empathy in this parallel phenomenology, however, is the one enacting empathy rather than the object of that empathy. The reshaping of the shamed subject and empathizing subject also takes different forms: the shamed subject is reshaped as if it they are what they assume the other *imagines them to be*, whereas the empathizing subject is reshaped as if they are *what they themselves imagine the other to be*. As a result, the empathizing subject strives to reach *towards* the one being empathized with, whereas *turns away* from the one who shames (at least in the very first instance—the shamed subject may indeed be compelled to move toward the one who shames to realign with the norm).

But what can ultimately happen in both the cases of empathy and shame is turning the objects of the verb (the one who is shamed or the one who is empathized with) into an other in problematic ways. This is more obvious in the case of shame: the one who is shamed is identified as having transgressed some norm which identifies them as other to a normative group or convention. The case of empathy is less intuitive, especially as in much of the phenomenology of empathy, respecting the difference of the other as other—as still different from oneself—is precisely the point. In her book *Medicine and Empathy*, Anne Whitehead traces Edith Stein and Matthew Ratcliffe's phenomenological model of empathy where 'in its other directedness, is responsive to difference'.¹⁵ Similarly, in his book *Self and Other*, Dan Zahavi argues how phenomenologists' conception of empathy 'highlights and respects what is distinctive about the givenness of others'.¹⁴ Emmanuel Levinas' ethics of encountering—being called to the face of—the other is also a good example of this kind of phenomenological model of empathy that respects the radical alterity of the other.¹⁶ But even this kind of empathy can go awry as Ahmed argues in her analysis and critique of Levinas in *Strange Encounters*.

For Ahmed, it is precisely Levinas' abstraction of the other (claiming to not know the other in any particular way) that ultimately represents the other as precisely *someone* who possesses alterity as an essential trait. Whereas Levinas may seek phenomenologically to describe an encounter with the other that is *before* knowledge, Ahmed argues that his figure of the other is already constructed as a fetishized stranger *through* knowledge: 'The stranger is someone we know as not knowing, rather than some-body we simply do not know. The stranger is produced as a category within knowledge, rather than

coming into being in an absence of knowledge'.⁴ The concept of stranger fetishism is central to Ahmed's critique: 'it invests the figure of the stranger with a life of its own insofar as it cuts "the stranger" off from the histories of its determination'. Ahmed draws largely upon Marx to develop her argument about stranger fetishism: fetishization involves the displacement of social relations through the transformation of objects or subjects into figures, which thereby cuts those figures off from their social and material relations.⁴ The stranger as a fetishized figure in the philosophies of thinkers like Levinas risks homogenizing and universalizing the stranger, the other, thereby actually erasing important forms of difference, rather than respecting difference. Thus, somewhat paradoxically, in reaching out to the empathized object—the other—as someone we ultimately cannot know, the empathizing subject risks transforming the other into a particular kind of other that we do indeed know as a stranger: as cut off from the complex web of contexts, circumstances, and connections that brought them to encounter or face the empathizing subject in the first place. What started as a transcendence of other becomes a thematization of the other as stranger. Thus it is not only the phenomenology of being shamed, but also the phenomenology of empathizing that can, somewhat paradoxically, other the other—the shamed self as an other who is known to be outside a norm or the empathized object as an other who is known outside of context.

But it is important to note that this othering through shame and empathy *can* happen, not that it necessarily always *does or has to* happen. This is where a critical phenomenology, like that of Ahmed, offers a different approach to empathy that does not transcend or fetishize an other, but rather seeks to recognize and attend to the cultural-political context of the one who is being empathized with. This also raises the question of whether shame also has such possibilities: perhaps if shaming is not levied towards individuals who transgress cultural-political norms, but rather levied towards institutions that create and contribute to reifying such norms, shame can be used in productive, progressive ways. When shame and empathy are simplistically viewed as working in opposition, rather than teasing out the nuances of where and how their phenomenologies are actually similar, shame remains an unquestioned 'bad' and empathy remains an unquestioned 'good.' Good as in the adjective: a good, even noble way to interact with others. But also a good as in the noun: empathy produces the object of its attention as an other—as a kind of fetishized good. Dolezal argues that shame 'is a permanent, necessary and structuring factor of identity. However, it is a double-edged force; it contains the potential for individual and social transformation, while also containing the potential for world-shattering personal and social devastation'.³ Empathy, in both its colloquial and phenomenological understandings, is also critical and indeed fundamental to identity development by developing one's relationships with others. But empathy too is a double-edged force that contains the potential for 'individual and social transformation,' as well as the potential for 'world-shattering personal and social devastation.' When healthcare views shaming and empathy as working in opposition, it maintains the illusion that empathy is only 'good' and shame is only 'bad,' thus missing the 'double-edged' potential for both

to be transformative or oppressive at the individual or institutional levels. To explore this further, the phenomenological encounter must be expanded beyond just a meeting between an 'I' and 'other' as two individual human subjects.

For Ahmed, 'meetings do not have to involve the face-to-face encounter of at least two subjects. Meetings do not even presuppose the category of the human person. More generally, a meeting suggests a coming together of at least two elements'.⁴ Such elements could be a patient and doctor, of course, but also the objects in such an encounter, like a stethoscope and heart sounds. If one moves outside the confines of the doctor's individual office, one can think of the encounter between patients waiting to be seen by a nurse practitioner and the space of the waiting room itself. The encounter between the electronic medical record system and thousands of patients. The encounter between a hospital's institutional policies and resources and the people who work within their confines. The encounter between what counts as 'best practices' in an evidence-based medical model and another medical model. The encounter between biomedical knowledge and other forms of knowledge, like phenomenology. This is how one can move between the phenomenology of shame and empathy at the level of one-on-one clinical encounters to the level of encounters between a mass 'public' and global and public health institutions. In their article 'Swimming in a Sea of Shame: Incorporating Emotion into explanations of institutional reproduction and change', Creed et al.¹⁷ 'reinvigorate institutionalism's phenomenological roots by populating institutional processes with emotional and socially embedded people'. They specifically focus on how individuals are embedded in a 'shame nexus' which includes 'a person's *sense of shame*, an internal mechanism of intersubjective surveillance and self-regulation; *systemic shame*, an intersubjective form of disciplinary power comprising shared understandings of the conditions that give rise to felt shame; and *episodic shaming*, a form of juridical power aimed at preventing or extinguishing transgressive enactments by inducing felt shame'.¹⁷ Understanding shame as a complex nexus gets us back to how shaming does not necessarily result in felt shame, and even when it does, the felt shame can result in varied responses from seeking to reintegrate with the shaming norms/group to challenging and even rejecting them entirely. This is where shame has the potential to either reify or disrupt institutional norms.

Ahmed provides an example of felt shame resulting in the reification of institutional norms through her analysis of collective expressions of national shame in Australia regarding the nation's failed responsibilities to Indigenous peoples. She theorizes that 'the expression of shame is a political action, which is not yet finished, as it depends on how it gets "taken up". Shame, in other words, does not require responsible action, but it also does not prevent it'.⁵ Expressions of empathy are like expressions of felt shame insofar as they are also unfinished: empathy does not always prevent responsible action, but it does not necessarily require or include it. Empathy prevents responsible action precisely when it is perceived to be a completed, responsible action on its own, thus foreclosing the need for any further action. Ahmed⁵ continues to explore how the

Australian nation 'may bring shame "on itself" by its treatment of others; for example, it may be exposed as "failing" a multicultural ideal in perpetuating forms of racism'. She goes on to explain how 'those who witness the past injustice through feeling "national shame" are aligned with each other as "well-meaning individuals"; if you feel shame, you are "n" the national, a nation that means well [...]' In other words, our shame *means that we mean well*, and can work to reproduce the nation as an ideal' rather than actually bringing tangible justice to Indigenous peoples.⁵ This also applies to empathy: those who witness the injustices faced by their patients through empathy can prevent responsible action when they become aligned with each other as 'well-meaning individuals' who reproduce healthcare as an ideal empathetic, helping enterprise at the individual-to-individual level without actually having to do any further work to make healthcare just at a systemic level. On the other hand, however, such empathy could alert one to injustices in healthcare and incite them to actually take further responsible action, for example through policy changes. Thus depending on how empathy or shame are 'taken up' in healthcare, they can end up working for or against oppression, for or against transformation.

While Ahmed built her argument around an example of felt shame, the argument can also apply to shaming. Shaming unvaccinated individuals or groups can also align such 'well-meaning individuals' in a way that reproduces themselves as an ideal group in such a way that does not necessitate and sometimes even prevents responsible action that actually changes vaccination uptake. This is where shaming individuals or groups for not getting vaccinated does not necessarily 'work' as it is only an unfinished political act. However, in the opening example of shaming the government for allowing private corporations to maintain patents and profits off the COVID-19 vaccine, shame did indeed 'work' to incite a further political act (i.e., denying these private pharmaceutical companies the right to patent the vaccine) that will make vaccines more accessible globally and hence tangibly increase their uptake. In the words of Naomi Klein, shame 'worked' against oppression as just one (albeit small) step towards global vaccine equity. But returning to the context of shaming individuals or groups, rather than institutions like the government or private corporations, one can easily imagine or have experienced how such shaming can, in fact, prevent responsible action by alienating that person who feels shame, triggering defensiveness, and ultimately pushing them further from ever getting vaccinated. As such, shame's potential to 'work' depends on whether it is levied at an individual or an institution or anything in between.

In her book *Is Shame Necessary?*, Jennifer Jacquet argues that 'shame's service is to the group, and when it is used well and at the right time, it can make society better off' and in order 'to maximize effectiveness, it often can be better to focus on institutions, companies, or countries rather than individuals'.¹⁸ She provides numerous illustrative examples of shaming working well, and not so well, and ultimately presents seven 'habits' of effective shaming: 'the transgression [being shamed] should (1) concern the audience, (2) deviate widely from desired behavior, and (3) not be expected to be formally punished. The transgressor should (4) be part of the group



doing the shaming. And the shaming should (5) come from a respected source, (6) be directed where possible benefits are highest, and (7) be implemented conscientiously.¹⁸ The above example of shaming the government for its role in global vaccine inequity meets all seven of Jacquet's criteria for effective shaming. The transgressor is a government whose policies allow pharmaceutical companies to patent and profit life-saving vaccines, which is a transgression that concerns a global audience (habit 1), deviates widely from the generally desired behavior to save lives through accessible healthcare (habit 2), and cannot realistically be expected to be formally punished (habit 3). The transgressor (the government) is ultimately part of, or at least a representative of, the same group (the public) that is doing the shaming (habit 4). And the shaming comes from respected sources, like Naomi Klein herself (habit 5), is directed at a policy-level intervention where possible benefits are highest (habit 6), and is implemented conscientiously insofar as protesting against government actions is generally acceptable in a democratic society (habit 7). Ultimately, shaming here heightened the visibility of the government's transgression and was effective in inciting the government to be tangibly, politically responsible and responsive.

But such heightened visibility through shame is not so effective when levied at individuals. Dolezal writes: 'Shame is about visibility. When one experiences shame, one is seen (by oneself or others) to be doing something untoward or inappropriate'.³ Pushed further, when one experiences felt shame, one is not just seen (by oneself or others) to do something untoward or inappropriate, but to actually *be* something untoward or inappropriate. To see an individual, such as someone who is not vaccinated as *being* untoward, even morally inferior, is a very different thing than making visible an institution or system as such. This is where the empathetic view of unvaccinated groups comes in: many strive to empathize with, for example, unvaccinated Black folks, by claiming to understand how it is reasonable given the history and present of racism in Western medicine. Here the capacity or willingness to empathize is dependent upon recognizing what systemic factors are at play with regards to COVID vaccinations. Just as it is critical to consider how the reasons for not getting vaccinated is dependent on social structures, it is critical to recognize that 'shame is not experienced in the same manner by all subjects. In fact, the propensity to shame, and its consequences, is very much dependent on one's position within a social group'.³ It's not just the propensity to shame that is determined by power, but so too is the propensity to *be* shamed and to respond to it: 'Each body subject does not have equal power when it comes to returning or "receiving the Look." As a result, some bodies are more prone to shame than others'.³ This is where a critical phenomenology of shame and empathy that accounts for their cultural politics comes in: is the shame around vaccines disproportionately levied towards and harming already oppressed subjects like Indigenous, Black, and disabled communities with valid reasons to mistrust Western medicine? And if empathy is to be effective in convincing such vaccine hesitant subjects to get vaccinated, then it must not only attend to such systems at play, but also incite changes in these systems. In this way, empathy can indeed be a tool working towards social justice.

But here lurks a double-edged sword yet again: in such a move to empathize with unvaccinated people by attending to the cultural politics of their relationship to healthcare, such oppressed groups risk being thematized as victimized others of healthcare without the more complex capacity to think or act beyond that trauma and their oppressed positions. In other words, through empathy, these communities may inadvertently become mere objects of their circumstances—fetishized objects of poverty, racism, ableism, more. In writing about shame, Dolezal draws upon Sartre's phenomenology to elucidate how encountering the other can be objectifying: 'to be objectified in this sense involves a process whereby one person sees or treats another person as a type of object (rather than as a transcendence, i.e., as a human being whose complexity eludes simple thematization) [...] The objectification of my character is likened more to thematization: instead of being regarded as a complex subjectivity, I am merely regarded as some aspect of my character: as a voyeur, a sneak or vulgar, for example'.³ The experience of objectification is central to feeling shame, but so too can it be a feature of empathy when the empathizing subject thematizes the other as only one aspect of their character, perhaps as a stranger or as an oppressed victim.

When one looks at the data from a July 2021 vaccination coverage survey in Canada, for example, this objectifying empathetic perspective on vaccine hesitancy has a tenuous basis: Indigenous people below 60 were found to have higher vaccination rates than nonindigenous people, and the rates above 60 are nearly equal,¹⁹ although a more recent study in the *Canadian Medical Association Journal* did find rates of vaccination among First Nations, Inuit and Métis in Toronto and London, Ontario to be lower than the rates for the two cities and Ontario.²⁰ Anishinaabe scholar Veldon Colbourne has researched vaccine uptake in Indigenous communities for over a decade, and he has found the popular discourse on vaccine hesitancy and medical mistrust in Indigenous communities 'overlooks [Indigenous peoples'] competency and health literacy, particularly their participation and embrace of contemporary medical practices' and thus can end up reifying stereotypes instead of focusing on the potential for positive change.²¹ There exists a similar discourse around empathy towards vaccine hesitancy and medical mistrust amongst Black communities in the United States and Canada.²² A closer look at the data in the United States, however, shows that contrary to the popular discourse, 'Black individuals overcame their hesitancy more quickly [than white individuals]' which 'underscores the importance of ongoing research and practical efforts to ameliorate a range of barriers to receiving the COVID-19 vaccine'.²³ This is all to say: it is not just shame that can objectify unvaccinated populations, but so too may empathy by reifying certain communities as singularly oppressed others without the further necessary action of addressing structural barriers to vaccination.

We can also turn our attention to how healthcare workers are being shamed for, on the other hand, pushing for not only increased vaccination uptake but also vaccine mandates. In an article on 'COVID-19, online shaming, and health-care professionals,' Luna Dolezal, Arthur Rose and Fred Cooper remarked how the 2020:

resurgence of the hashtag #NoToDoctorShaming on Twitter highlighted the problem of online shaming of health professionals. Doctors are often held up to superhuman standards that demand infallibility. Common human occurrences, such as making mistakes, falling sick, needing sleep, or displaying emotion could be potential opportunities for shaming. Working on the front line of medicine, health-care workers are often blamed, or are perceived to be responsible, for system-wide problems such as staff shortages, short appointment times, insufficient bed space, PPE shortages, long waiting lists, or limited treatment options. Such pressures are compounded by the emotional and physical strain that comes with long working hours and having high caseloads, all of which have been exacerbated during the COVID-19 crisis.²⁴

Here shaming healthcare workers themselves for being weak, fallible, burned out and even angry prevents the kind of political action that is necessary to actually improve the working conditions for healthcare workers and thereby patient care. One such political action would be to mandate vaccination to decrease COVID-19 rates that are pushing such healthcare systems and the people who work in them to the brink of collapse. In Canada, for example, the script of shame has flipped such that healthcare workers are shaming the government for its inaction regarding vaccine policies, leaving the burden to care for those who get COVID-19 to an already overworked healthcare workers and system. Meanwhile there have even been antivaccination protests happening outside hospitals across the country, where even ambulances are blocked from reaching the hospital and individual healthcare workers are shamed and harassed upon entering and exiting the building.²⁵ Here shame is again levied towards individuals, and ultimately allowed to do so by a government that is unwilling to take serious political action. Drawing upon Dolezal's words, shame has become 'a structural feature of cultural politics' and thus 'it is not enough to overcome shame individually, but it must be done collectively'.³

On the other hand, there has been a rise in empathy towards healthcare heroes, most notably demonstrated through the #HealthcareHeroes movements across the globe. There is a renewed understanding, respect, and empathy for how difficult a healthcare worker's job is and how they rise up to the challenge. But here again, empathy forestalls political action by still putting the burden on individual healthcare workers to be overworked heroes without actual systemic support. Again in Canada, there has been significant backlash by healthcare workers against being called a healthcare hero precisely because it distracts and absolves institutions from necessary action to improve the working conditions of such supposed heroes—significantly including vaccine mandates.²⁶ Many hospitals have by now instituted their own vaccine mandates, but the government has never made it a requirement for even hospital workers, let alone the population at

large. In the case of healthcare worker burnout, a perhaps better approach to empathy than the healthcare heroes narrative would be one that makes visible the many failures of a healthcare system to actually support its workers, from the 26 h shifts medical students and residents work to the government's failure to mandate vaccines in hospitals at the very least.

Here we have circled back, in perhaps unexpected ways, to Garden's earlier caution that empathy must not obscure larger social contexts and especially power imbalances. Through the development of the phenomenologies of shame and empathy, and their application to the case of COVID-19 vaccination, I demonstrate how such affects work in more complex, vexed, and even contradictory ways than typically considered. Attending to such nuance is critical if one is to work towards effectively levying shame and empathy towards justice rather than further oppression. There are no tidy conclusions to make here—and that is precisely the point: to problematize these affects, not to 'to hand you after an hour's discourse a nugget of pure truth to wrap between the pages of your notebooks and keep on the mantelpiece for ever,' in the words of Virginia Woolf from the opening of her seminal text *A Room of One's Own*.²⁷ In her chapter on 'Virginia Woolf and the Limits of Empathy,' Meghan Marie Hammond provides readings of several of Woolf's texts, notably including *A Room of One's Own*, and argues that Woolf rejects 'fellow feeling as a guiding principle for ethical action'.²⁸ But in my analyses of phenomenology and the case of COVID-19 vaccinations, I do not reject empathy nor shame entirely. This is perhaps the closest I will come to offering a conclusion: while empathy and shame *do not necessarily* guide ethical actions or decisions, they still *can* if used in critically reflexive ways.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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