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Medical empathy in the physician-patient relationship: A review from a cultural perspective

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Background: *Medical empathy is a fundamental pillar in the social construction of the physician-patient relationship. In this light, patients' beliefs and perceptions of medical empathy, and physicians' empathic attitudes towards their patients are guided by their socio-cultural understandings and expectations, which naturally vary from culture to culture. Such considerations are particularly relevant to the field of social psychology and to public healthcare systems where a growing number of foreign physicians characterise their highly diverse socio-demographic makeup. However, there is no clear research agenda concerning the way in which medical empathy should be investigated from a cultural point of view in years to come.* ***Aim****: To this end, the paper presents a systematic review of studies that examines medical empathy in healthcare contexts from a cultural perspective to synthesize their findings, evaluate their limitations and propose future lines of research.* ***Material and Methods:*** *The review considers articles published from January 2010 to June 2022 in the PubMed, Scopus and Web of Science databases and follows the PRISMA methodology.* ***Results:*** *Three studies, of the 314 articles analysed, met the criteria established for this investigation. The analysis shows that research on medical empathy has analysed the cultural diversity of physicians of a limited range of cultural backgrounds, exclusively from a cross-cultural perspective, employing quantitative research designs and exclusively using the Jefferson Medical Empathy Scale.* ***Conclusions****: We suggest that future studies adopt an intercultural perspective of medical empathy as a psychocultural construct rather than as merely a sociocultural one.*

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Key words: *Cultural Diversity; Empathy; Physicians.*

La empatía médica en la relación médico-paciente: Una revisión desde una perspectiva cultural

Antecedentes: *La empatía médica es un pilar fundamental en la construcción social de la relación médico-paciente. En este sentido, las creencias y percepciones de los pacientes sobre la empatía médica y las actitudes empáticas de los médicos hacia sus pacientes están guiadas por sus entendimientos y expectativas socioculturales, que naturalmente varían de una cultura a otra. Tales consideraciones son particularmente relevantes para el campo de la psicología social y para los sistemas públicos de salud donde un número creciente de médicos extranjeros caracterizan su composición sociodemográfica altamente diversa. Sin embargo, no existe una agenda de investigación clara sobre la forma en que la empatía*

*médica debe investigarse desde un punto de vista cultural en los próximos años. **Objetivo:** Para ello, el artículo presenta una revisión sistemática de estudios que examinan la empatía médica en contextos sanitarios desde una perspectiva cultural para sintetizar sus hallazgos, evaluar sus limitaciones y proponer futuras líneas de investigación. **Materiales y Métodos:** La revisión considera artículos publicados desde enero de 2010 hasta junio de 2022 en las bases de datos PubMed, Scopus y Web of Science y sigue la metodología PRISMA. **Resultados:** Tres estudios, de los 314 artículos analizados, cumplieron con los criterios establecidos para esta investigación. El análisis muestra que la investigación sobre la empatía médica ha analizado la diversidad cultural de los médicos de una gama limitada de antecedentes culturales, exclusivamente desde una perspectiva transcultural, empleando diseños de investigación cuantitativos y utilizando exclusivamente la escala de empatía médica de Jefferson. **Conclusiones**: Sugerimos que los estudios futuros adopten una perspectiva intercultural de la empatía médica como una construcción psicocultural en lugar de una meramente sociocultural.*

***Palabras clave:** Diversidad Cultural; Empatía; Médicos.*

Medical empathy (hereinafter, ME) is key to the modern medical culture and has been defined as the sense of connection that is established between the health professional and the patient as a result of affective and cognitive processes[1]. ME is conceived as the basis of a compassionate and positive interpersonal relationship that seeks the well-being of the patient based on the consideration of their cultural, ethical, psychological, biological, social and spiritual needs and characteristics. It is then considered to be a fundamental pillar in the psychosocial construction of the physician-patient relationship (hereinafter, PPR) and a key aspect of medical training and the psychological treatment of patients[2], since it allows the physician to go beyond the symptom and illness, and to focus on the patient and their humanized medical care[3]. The importance of ME in the PPR has been assessed in terms of improvements in care and patient satisfaction, because it helps to develop greater trust and communication in the PPR, and patients' adherence to treatment[4-6]. It has also been shown that physicians with high levels of emphatic behaviour report higher levels of professional satisfaction, which contributes to lower levels of stress and burnout[7].

Since the late 21st century, the cultural understanding of ME has undergone significant changes in the PPR due to important sociodemographic changes in health systems resulting from high migration waves of professionals, mainly in countries such as the United Kingdom, Spain, Australia, Canada and the United States[8], a phenomenon coined by Eastwood[9] as the "medical carousel"[10]. This has also been the case in a number of Latin-American countries. In particular, Chile has experienced an explosive growth of migrant physicians during the last 10 years, mainly due to its attractive labour market[11]. In this regard, the Superintendence of Health registered about 2,818 foreign physicians in 2017 (a much higher figure than the 432 registered in 2010), and 4,518 foreign physicians[12] who during 2019 sat the Examination National Single Knowledge of Medicine (EUNACOM)[i], where 93% of the physicians who took the test were foreign physicians. In addition, these migration waves have resulted in a marked increase of migrant patients in the public healthcare system[ii], which has also contributed to the sociodemographic complexity of patient care in the PPR.

As a result of the migration of physicians, the cultural background, the theoretical models under which they practice medicine and their professional experience in foreign countries influence their empathic attitude and behaviour towards their patients. When physicians of different nationalities

[i] The EUNACOM is contained in Health Decree N° 8 of 2009 and is the national test that all recently graduated Chilean physicians and/or all foreign physicians who wish to revalidate their title in Chile must sit and pass to be able to work in the public healthcare system throughout the national territory (Ministry of Health 2018).

[ii] https://www.minsal.cl/salud-del-inmigrante/

coexist in public healthcare institutions, they develop medical interactions for the care and treatment of patients under the vision of their own cultures, which involves substantial changes in the PPR[13-15]. In this light, because the social construction of ME depends on the various belief and ideology systems influenced by the cultural background of interactants, this is an ever-changing factor as new migration waves take place. It is then vital to investigate the changes in the construction of the ME in the PPR as a result of current migratory movements. In particular, the cultural richness of the current public healthcare system in countries like Chile highlights the need to develop a culturally situated understanding of ME and to further investigate the social and interactional construction of ME from an intercultural perspective to assess the way it affects the effectiveness of the treatment in the PPR. However, the literature on the construction of ME in the PPR in intercultural contexts remains scattered and inconclusive.

Thus, in order to move the field forward, we need to assess the research needs in the area and to outline an intercultural research agenda for the study of ME in the PPR that is appropriate to current social phenomena. To that end, this paper offers a systematic review that critically examines the bibliography on the construction of ME in the PPR from various international contexts, with special attention to the literature from Chile, and proposes recommendations for future research in this area with the aim of advancing the field of intercultural studies in healthcare systems.

Methodology

A systematic review of ME studies that have addressed the relationship between local and foreign physicians with their patients was carried out in July 2022. Scientific articles published from January 2010 to June 2022 were selected and analysed following the guidelines of the PRISMA statement[16]. A broad free text search was conducted in Spanish and English in PubMed, Scopus and Web of Science (Figure 1). The analysis of the articles was independently developed by the two authors, who, when presenting disagreements, resolved them through discussion. All empirical articles that investigated ME in the relationship between local and foreign physicians with their patients (including physicians in specialization training) were included. We excluded studies that: 1) involved health professionals other than physicians (such as nurses) as participants; 2) did not have the aim of investigating ME in intercultural

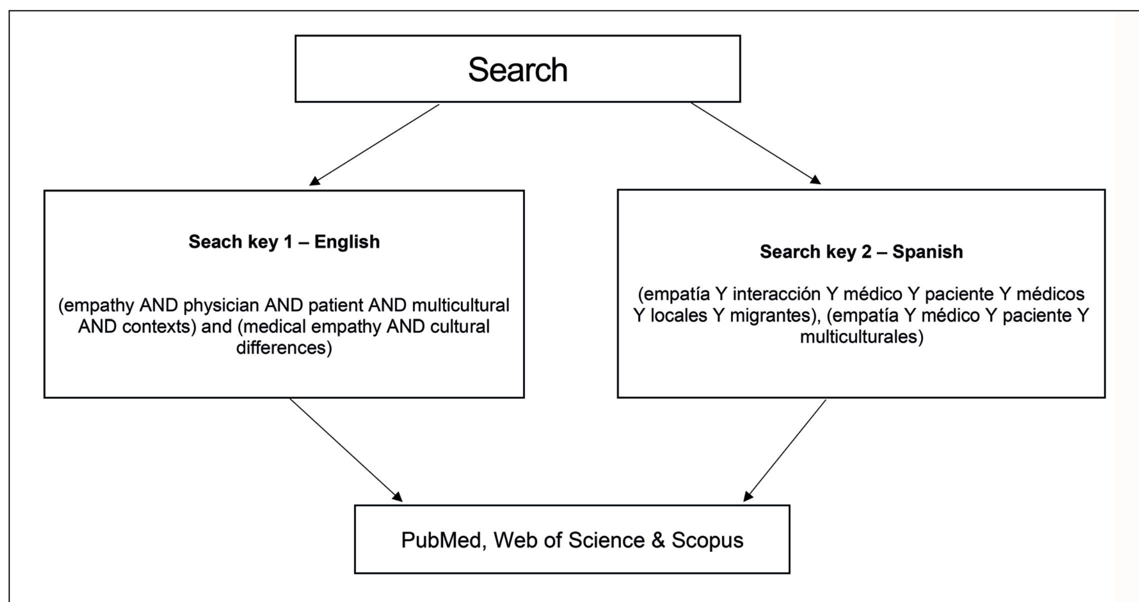

Figure 1. Search keys.

interaction between physicians and patients; and 3) did not empirically examine ME in the PPR in intercultural contexts (e.g. review articles, notes, editorial comments and essays, among others).

Information of the selected articles, including the year, author, title of the article, general objective, method(s) of data collection and of data analysis, participants and context, main findings, limitations of the studies and journal information, was entered on an analysis grid. The process of filtering the results was carried out through an analysis of the content of the articles[17] in which only those that met the inclusion criteria were reviewed and analysed. The remaining articles (e.g. reflection pieces) were later classified into categories that allowed us to understand current scholarly thinking of the concept of ME particularly in the last twelve years in a more general way.

Results and analysis

The results show that, of a total of 314 articles found, only three studies met the objective of addressing ME in the relationship between local and/or foreign physicians and their patients (Figure 2). The three studies were carried out in Spain between 2015 and 2016, although it should

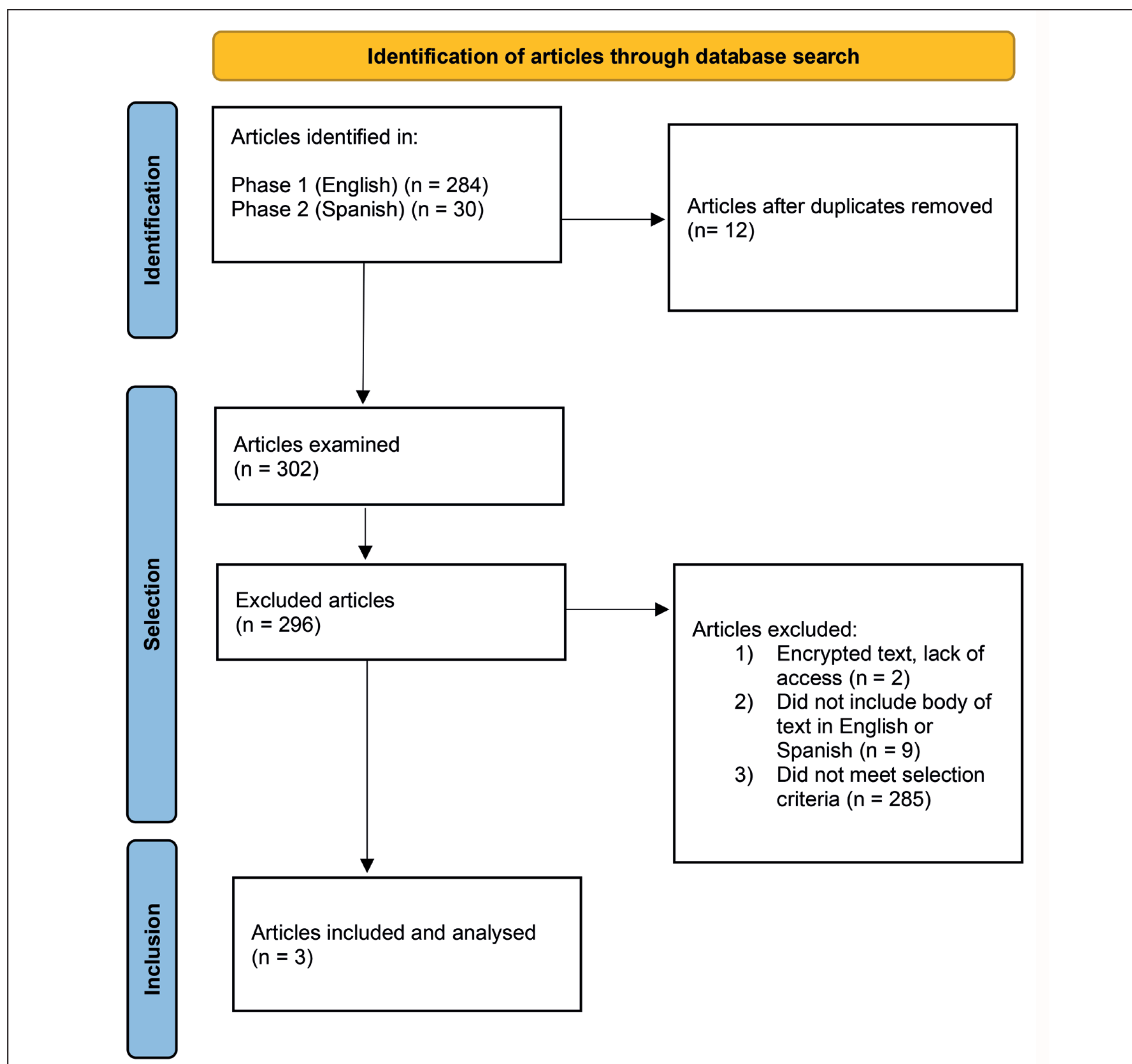

Figure 2. PRISMA flow diagram (adapted from Page et al., 2021).

be noted that one study[18] considers practicing physicians and physicians-in-training from 13 health centres in five countries (Spain, Mexico, Colombia, Bolivia and Argentina) as part of their sample. The other two studies investigated ME in resident physicians (i.e. physicians-in-training) of different nationalities in public health centres of specialized medical training in Spain[19-20].

In regards to the aims of the studies analysed, the investigation by Alcorta-Garza et al.[18] sought to do a cross-cultural validation of the Jefferson Medical Empathy Scale (translated into Spanish) by confirming its psychometric properties in Spanish and Latin American contexts, as well as measuring the influence of social and cultural factors on the development of ME in physicians. To achieve this, 896 participating physicians and residents were classified into three groups: Spaniards living in Spain, Latin Americans living in Spain, and Latin Americans who had never left their country of origin. Moreover, the study by Delgado-Bolton et al.[19] sought to characterize the contextual factors that affect the development of ME and that are sensitive to cultural differences in Spanish and Latin American medical residents, through the application of 104 questionnaires. Participants were medical residents who, at that time, were doing the first of four years of residency in 22 programs for primary care and hospital medicine. On the other hand, the study by San Martín et al.[20] sought to identify similarities and differences of ME in inter-professional collaborative work skills, and in lifelong medical learning skills among 150 Spanish and Latin American medical residents who did their specialized training in Spanish teaching hospitals.

The three studies analysed are quantitative in nature, as they all measure ME using the Jefferson Medical Empathy Scale in its version for professionals (JSE-HP) and also employ a sociodemographic questionnaire to establish (cor) relations between the scales. When comparing the cultural groups of physicians, the three studies show significant differences, with a p value of 0.01 in Delgado-Bolton et al.[19], of <0.01 in Alcorta-Garza et al.[18] and of 0.03 in San Martín et al.[20], which accounts for the existence of significant differences in patients' perception of empathic treatment of national and foreign physicians. These differences are larger when comparing Spanish physicians to Latin American physicians. Likewise, Latin American physicians doing their residency in Spain showed higher scores of ME towards their patients compared to physicians working in Latin-American countries[18]. However, these differences in ME are not observed in the scores for medical residents[19], while there are significant differences (p <0.001) between residents and practicing physicians, as the latter present lower scores of ME towards their patients[18]. With respect to resident physicians, those who were involved in a continuous training process (physicians who, after graduating, continued their specialization studies the following year) displayed higher scores of ME towards their patients (p 0.008) than those who, for instance, had to discontinue their studies to comply with work requirements in rural locations[19].

Regarding the relationship between physicians' specialty and their empathic treatment, a greater ME was found in family physicians with respect to surgeons, with significant differences between both groups[18]. In regards to gender, significant differences were found in the ME scores between male and female physicians, the latter displaying higher ME scores in two of the studies[18,20]. Finally, with respect to age, a significant inverse association was found in San Martín et al.[20] (r = ---0.19; p = 0.02) and Delgado-Bolton et al.[19] (r = −0.22; p < 0.03), which shows that older physicians got lower ME scores.

In regards to the studies' limitations, only Delgado-Bolton et al.[19] acknowledged limitations regarding the study design and recommended developing longitudinal studies that investigate the socio-cultural processes involved in the development of ME throughout physicians' formation trajectory. In addition, San Martín et al.[20] addressed limitations regarding the fact that the kind of sample used did not allow the exploration of further relationships between the variables studied, while Alcorta-Garza et al.[18] suggested conducting studies with larger sample sizes.

Discussion

The results of this systematic review provide valuable information regarding the very few investigations found that address ME from the point of view of the relationship between local (or national) and foreign physicians with their patients. The

findings show that ME research that explores the cultural diversity of physicians is a fairly recent field of study, and, thus, the three studies analysed here make a substantial contribution to the field. However, in order to move the field forward, we outline the main weakness identified in this study that help identify future research avenues.

To begin, the three studies investigate ME exclusively through a quantitative approach (all three using the Jefferson Scale) and only involve physicians undergoing some level of professional training (e.g. residents). Both of these factors provide a limited perspective on the exploration of ME from an intercultural perspective[21], and it is, therefore, necessary to develop future studies on ME that focus on practicing physicians, especially in contexts with high demand for healthcare services. In this regard, previous studies show that ME scores vary to great extents when comparing medical students, residents and practicing physicians, displaying a marked decline in empathy and other humanistic qualities as physicians move up the career ladder[22]. Such differences may be even more dramatic in intercultural contexts where cultural expectations of the realization of empathic behaviour may be unknown to interactants, which makes this an interesting area for further research.

In addition, in order to reduce the social desirability bias often found in the use of self-report questionnaires, employing a mixed methods approach that incorporates qualitative methods and, in particular, participant observation methods and naturally-occurring recordings of actual physician-patient talk and interactions would allow researchers to explore how ME is constructed and perceived in actual practice[23-24]. While the advantages of using mixed methods design have been widely documented in the healthcare literature of intercultural communication[25], we were not able to find this methodological richness in intercultural studies of ME. Future studies that develop a mixed methods approach to ME in intercultural contexts may be able to use a diversity of data collection and analysis techniques that help combine disciplinary traditions (e.g. psychology and sociology) to capture the complexities of the construct[26].

In this line, it is also interesting to bear in mind the results for the physicians in training of Spanish nationality, which raise questions as to whether medical training in multicultural contexts may have a more positive impact on patients' perception scores of ME. In this light, it should be highlighted that the articles analysed in this study investigated ME without exploring its relationship with other social and/or psychologically relevant variables. In particular, it would be interesting to investigate the role of psychological factors (e.g. physicians' personality traits, compassion fatigue and burnout)[27] in mediating ME perceptions of and about foreign physicians over the years (i.e., across their career trajectory), and to explore the possible relationship among these variables, physicians' training models (i.e., biomedical or biopsychosocial) and the quality of patient care, treatment and recovery.

Moreover, the cultural contexts (i.e., Spanish and Latin American physicians) in which these studies of ME have been developed and the cross-cultural perspective they adopt (i.e., a comparison of cultural groups that do not interact with each other) also offers a narrow view of this social phenomenon. It is, therefore, vital to explore not only other (multi)cultural realities[1], such as the Chilean one (for which no studies of this nature have been found), but also to do so from an intercultural standpoint, that is, exploring how physicians and patients from different cultures construct and perceive ME when they actually interact with each other.

In addition, the three studies analysed were developed in public hospitals. This makes the exploration of other public care contexts (e.g. rural healthcare services) and private contexts (e.g. specialised clinics) an interesting choice, since very often the different healthcare territorial units coexist to manage health promotion and prevention, yet they have their own culturally-situated norms. Research in such settings could expand our knowledge and awareness of ME across contexts by exploring psychological and the cultural aspects of ME at macro, meso and micro cultural levels [(28)] to identify new research gaps. Finally, the studies analysed did not consider ME from patients' perception of the cultural diversity of the physician. The invitation then is to pursue investigation of ME that considers the perspective of the patient as a key informant to advise and improve healthcare services by viewing ME not just as a merely affective[29], or as an exclusively socio-cultural aspect of the PPR, but rather as a psychocultural construct[30] that involves both aspects, an internal (psycholo-

gical one) and a social one. From this perspective, the field of intercultural psychology[31] has much to offer to the study of ME in the PPR, even when, unfortunately, it has rarely been employed in related healthcare communication research. Viewing ME in the PPR from an intercultural psychology angle would allow researchers to investigate psychocultural process of acculturation and adaptation in the construction of ME between physicians and patients. It would also allow them to explore several aspects of physicians' and patients' cultural identities, such as the role of empathic behaviour in displaying cultural belonging.

All in all, while the reviewed studies provide solid grounds on which to inform medical education initiatives, to be able to inform public health policy and to define relevant strategic agendas of medical practice that promote the cultural integration of foreign physicians across healthcare contexts and improve the PPR and treatment outcomes, further insights into the psychocultural aspects of ME and how it is socially constructed and perceived in actual medical practice that involves all relevant stakeholders (i.e., physicians and other health professionals, patients, family members of patients and administrative staff) are needed from an intercultural perspective.

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