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Authors
Schwartz, Rachel
Blanch-Hartigan, Danielle
Valbuena, Gustavo
et al.

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Letter to the Editor in response to Swami et al.

Addressing Cultural “Empathy” in Clinical Practice

Rachel Schwartz, PhD1*, Danielle Blanch-Hartigan, PhD, MPH2, Gustavo Valbuena, MD, PhD3,
Amy Weil, MD4, Manisha Dubey, BSPH5, Hannah Z. Catzen, BA6, Judith A. Hall, PhD7, Justin
J. Sanders, MD8

*Corresponding Author: rachel.schwartz@mail.mcgill.ca, 300 Pasteur Drive, MC 5603,
Stanford, CA 94305

Affiliations:
1Stanford University School of Medicine, Stanford, CA
2Department of Natural and Applied Sciences, Bentley University, Waltham, MA
3UC Berkeley/UCSF Joint Medical Program, Berkeley, CA
4Division of General Medicine and Clinical Epidemiology, University of North Carolina, Chapel
Hill, NC
5University of Colorado School of Medicine Anschutz Campus, Aurora, CO
6University of Michigan Medical School, Ann Arbor, MI
7Department of Psychology, Northeastern University, Boston, MA
8Palliative Care, McGill University, Montreal, Quebec, Canada

E-mail addresses: rachel.schwartz@mail.mcgill.ca (R. Schwartz), dhartigan@bentley.edu (D.
Blanch-Hartigan), gvalbuena@berkeley.edu (G. Valbuena), amy_weil@med.unc.edu (A. Weil),
manisha.dubey@cuanschutz.edu (M. Dubey), hcatzen@med.umich.edu (H.Z. Catzen),
j.hall@northeastern.edu (J.A. Hall), justin.sanders@mcgill.ca (J.J. Sanders).
Swami et al.\(^1\) call for research on cultural diversity in the understanding of clinical empathy. We support their assertions, and advocate for establishing the institutional climate needed to translate this research to better patient care. Below, we detail strategies for effecting this change.

**(Continuing) Medical Education: Cultural Humility and Communication Training**

Some medical schools have implemented anti-racism training programs, including student-led narrative medicine for anti-racism for students, residents and faculty,\(^2\) institution-wide training with a focus on awareness of privilege and bias,\(^3\) use of forum theater to explore racism and anti-racism,\(^4\) and guidance on language from national medical associations.\(^5\) Institutional investment in evidence-based clinical communication training can provide clinicians with tools for recognizing opportunities for culturally sensitive patient interactions.

Medical schools may also assist students in developing cultural humility, an approach that emphasizes continual self-critique, curiosity, vigilance towards stereotyping, and a commitment to mutually respectful and dynamic clinical engagement,\(^6\) throughout the curriculum. Teaching pathophysiology alongside the history of medicine might allow students to integrate the scientific fund of knowledge with the context in which this knowledge was inherited. How might students approach the biochemical mechanisms of cancer, and later, their own patients with malignancies, if this knowledge is grounded in the care of Henrietta Lacks?

In developing clinical skills, students might benefit from working with standardized patients from diverse backgrounds, and alongside interpreters to better reflect real life care delivery. Students could be taught that empathy is a clinical skill as important as formulating a differential
diagnosis, and given equal opportunity to practice conveying it with patients whose conceptions of empathy may differ based on cultural background.

Medical education is based in learning from other clinicians. It is care team members and, as clinical students, fellow classmates who demonstrate how to listen to, learn from, and build therapeutic relationships with patients from many backgrounds. Medical schools that integrate new approaches for recruiting and retaining diverse students and clinicians will possess an advantage; students will emulate the empathic approach of those whom they admire and trust--their leaders and peers.

**System-Level Strategies**

Although medical education and healthcare organizations routinely include elements of individual-level diversity training, efforts to develop and implement culturally-appropriate “empathic” communication at the systems-level are scarce. Such system-level efforts could include:

*Trauma-Informed Care practices.* This includes training clinicians how to decrease the provider-patient power dynamic and move towards a collaborative approach, inquiring sensitively about patients’ religious and cultural preferences regarding care and prior experiences of structural violence.8

*Addressing clinic environment factors to promote relational engagement.* This includes outreach to ‘level the playing field’, e.g., engaging patients via home visiting when possible/wished or telehealth, and hiring diverse clinical staff that more closely reflects the patient population
served. Our previous work demonstrated that system-level factors (accessibility, response times, team-based care practices) affect perception of clinician “empathy”.

Leadership and organizational climate in healthcare institutions and health professions schools must be invested in relational models of care delivery to fully support “empathic” clinical care for all patients.
References


