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Cultivating ethnocultural empathy in healthcare: The effects of multilingualism and cross-cultural experiences

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Abstract

Introduction: Empathy is a multidimensional construct essential to effective healthcare delivery, encompassing general, clinical, and ethnocultural components. While the importance of empathy in clinical settings is well-established, limited research has examined how these distinct dimensions interrelate and what sociodemographic factors may influence them. This study aimed to investigate the relationships among general, clinical, and ethnocultural empathy in healthcare professionals in Greece, and to identify sociodemographic predictors of higher empathy levels.

Methods: A cross-sectional study was conducted during the first quarter of 2022, involving a convenience sample of 106 healthcare professionals (medical and nursing staff) from public hospitals across Greece. Participants completed an electronic questionnaire distributed via professional Facebook groups. The instrument included the Toronto Empathy Questionnaire (TEQ), the Jefferson Scale of Empathy – Health Professional Version (JSE-HP), the Scale of Ethnocultural Empathy (SEE), and a sociodemographic survey. Data were analyzed using SPSS 26.0, employing descriptive statistics, Pearson correlation coefficients, and stepwise linear regression.

Results: Significant positive correlations were observed among general, clinical, and ethnocultural empathy scores. Higher levels of education, foreign language proficiency, and prior intercultural experiences (such as studying or living abroad) emerged as significant predictors of increased empathy across all three domains.

Discussion: The findings support the interconnected nature of empathy types and suggest that intercultural exposure may enhance empathic capacity, echoing Allport's contact hypothesis. These insights have implications for healthcare education, highlighting the need to integrate ethnocultural empathy training to foster inclusivity and improve patient-centered care in increasingly diverse clinical environments.

Take-home message: Foreign language proficiency and intercultural experiences (such as studying or living abroad) significantly enhance empathy among healthcare professionals. Fostering general,

clinical, and ethnocultural empathy through targeted training can improve inclusivity and patient-centered care in diverse clinical settings.

Keywords: empathy; clinical empathy; ethnocultural empathy; healthcare professionals; cultural competency.

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INTRODUCTION

Empathy encompasses both cognitive and emotional dimensions, which are crucial for understanding and sharing others' emotions, whether concerning individuals or population groups. Cognitive empathy, as defined by Kalisch [1], entails the mental ability to comprehend another's mental state, allowing one to imagine how another person feels, recognize their emotions, and understand their perspectives. This cognitive aspect is complemented by the emotional dimension, which includes an automatic emotional response to another's emotional state, encompassing empathy and its perspective [2].

The balance between cognitive and emotional dimensions is essential, as overall empathy requires not only understanding another person's emotional state but also demonstrating genuine concern for their well-being [3, 4]. Thus, overall empathy is recognized as a dynamic interaction among these dimensions, facilitating a deeper connection with others and enabling individuals to accurately recognize emotions, understand their meaning, and respond appropriately [5].

Although empathy has traditionally been explored in philosophy and psychology, recent decades have seen a growing body of research highlighting its significance in the medical, nursing, and healthcare fields [6-9]. Empathy exercised in clinical settings, termed clinical empathy, represents a distinct characteristic that requires a careful balancing act to optimize patient care and preserve the well-being of healthcare providers. In healthcare environments, clinical empathy goes beyond simply understanding others' emotional states; it requires healthcare professionals to engage with patients in a way that is both compassionate and therapeutic [10,11].

Larson and Yao [12] examined clinical empathy as a form of emotional labor, where healthcare professionals must not only comprehend patients' emotional states but also respond empathetically to improve patient outcomes and satisfaction. Indeed, patients who experience this type of empathetic interaction often report greater satisfaction with their medical care, as they feel genuinely heard and cared for, which can lead to improved outcomes [13]. This satisfaction underscores the social benefits that clinical empathy brings to the healthcare environment. Additionally, research in nurse-patient interactions has shown that empathic and affiliative responses by nurses help establish rapport and trust with the patients, allowing for more elaborate conversations which validate patients' medical concerns and could lead to optimized patient care results [14]. This is further corroborated by evidence from a study with breast cancer patients which unveiled that increased perceptions of empathic communication with the oncologist were associated with a higher patient disclosure efficacy [15]. In a similar vein, a recent systematic review by Zhang et al. [16] highlights that physician empathy enhances the effectiveness of doctor–patient communication, thereby playing a critical role in the diagnostic and therapeutic processes.

However, the expression of empathy must be approached with caution, as it can have detrimental effects on caregivers themselves. Excessive identification with patients' suffering may lead to emotional exhaustion and, in some cases, serious consequences such as burnout, depression, and trauma. These adverse outcomes highlight the necessity for healthcare professionals to develop strategies that allow them to express empathy while protecting their own mental health, as the

sustainability of empathetic care is crucial for both patients and (typical) caregivers. For this reason, recent research emphasizes the need to integrate empathy into the curricula of healthcare schools to facilitate the formation of a therapeutic alliance between healthcare providers and patients [7,17,18].

In our era, increased population mobility has resulted in the formation of multiethnic and simultaneously multicultural societies, contributing to the phenomenon of cultural globalization. The process of cultural globalization profoundly influences all aspects of culture, including religion, communication, and social organization [19].

In the health sciences, particularly in medicine and nursing, which are concerned with the care of individuals in states of physical vulnerability and dependency, sensitivity to cultural specificities is essential, as it is both an ethical and legal obligation for formal caregivers. Moreover, the development of a distinct type of empathy that addresses individuals' unique cultural characteristics (see ethnocultural empathy) is of primary importance for a successful holistic approach to patients from diverse ethno-cultural backgrounds.

Just as clinical empathy enhances patient satisfaction and outcomes within healthcare settings, ethnocultural empathy in diverse societies and cultural contexts plays a central role in fostering harmonious intergroup relationships and ensuring social inclusion and cohesion [20, 21].

The concept of ethnocultural empathy is relatively new in psychological literature [22]. It extends beyond merely feeling another's pain or joy; it requires a deliberate and active exercise of imagination to fully examine and understand the diverse lived experiences of individuals from different cultures [20, 21]. This imaginative effort resembles an exercise in constructing social reality, where one builds an expansive and diverse world within their mind, reaching out to grasp the essence of how others live, love, mourn, and thrive. Such an expansion of empathy is not passive; it is a creative form of work, requiring individuals to perceive and interpret phenomena from perspectives often very different from their own. This work is particularly critical given the tendency for in-group favoritism, which dictates who receives empathy, potentially contributing to intergroup conflict by excluding out-group members.

Thus, developing ethnocultural empathy is an intentional act of learning [23] that challenges individuals to transcend their perceptual boundaries, sparking curiosity to understand and empathize through a wide array of ethnocultural narratives.

In contemporary multicultural societies, ethnocultural empathy is a fundamental element of social cohesion and peace. In the clinical setting, ethnocultural empathy facilitates access to healthcare services for migrants and refugees and contributes to the elimination of social health inequalities among different ethnic and cultural groups.

A healthcare system that values and seeks to integrate ethnocultural empathy creates an inclusive environment where all patients feel welcome. Healthcare providers must be able to "navigate" cultural differences comfortably and provide care that respects the cultural values and needs of their patients [24]. This approach is essential for improving population health indicators, promoting health equity, and establishing the Health Democracy.

The purpose of the present research is to investigate the correlation among the three types of empathy mentioned above: general, clinical, and ethnocultural, as well as to examine the impact of the social and demographic characteristics of healthcare professionals who participated in the study.

METHODS

Study procedure and data collection

This is a cross-sectional study conducted nationwide during the first quarter of 2022. The electronic questionnaire was created using Google Forms, and the link was shared in both official and unofficial groups of healthcare professionals (physicians and nurses) on the social media platform Facebook. Indicative groups include: (a) the Hellenic Nurses Association and the National Association of Nurses of Greece for nurses, (b) the Panhellenic Medical Association and Greek Doctors for physicians.

A convenience sample was used, consisting of 106 members of the medical and nursing staff from public hospitals across the country. Specifically, the study included 74 nurses and 32 physicians,

40.6% of whom held a postgraduate degree (Master's and/or Doctorate). Among those with postgraduate studies, 8.5% had studied at a higher education institution abroad, while 10.4% had completed their undergraduate studies outside Greece. Regarding gender, 61 were women and 45 were men, with the majority (32.1%) falling within the 31-40 age group and being married (49.1%). Additionally, 88.7% of participants reported speaking at least one foreign language.

In relation to the varying participation rates between nurses and physicians in the study, the literature indicates that nurses tend to show greater willingness to participate in research compared to physicians [25], due to various factors such as professional culture [26], workload [27], research relevance [28], and incentives [29].

Study instruments

For data collection, a research package was used, consisting of the following questionnaires/scales: (a) the Toronto Empathy Questionnaire, which measures general empathy, (b) the Jefferson Scale of Empathy (HP-Version), for assessing clinical empathy, (c) the Scale of Ethnocultural Empathy, to explore participants' levels of ethnocultural empathy, and (d) a questionnaire with sociodemographic information, structured by the authors.

The Toronto Empathy Questionnaire

The Toronto Empathy Questionnaire (TEQ) [30] is a unidimensional, brief, and valid tool for assessing empathy. The primary purpose of developing the TEQ was to evaluate empathy primarily as an emotional phenomenon, although it includes aspects related to the cognitive dimensions of empathy. The questionnaire consists of 16 items, which participants complete using a five-point Likert scale (0 = never, 4 = always). Scores are summed to yield a total score, which can range from 0 to 64. High scores indicate high levels of self-reported empathy, while a score below 45 suggests below-average levels of empathy.

Jefferson Scale of Empathy

The Jefferson Scale of Empathy (JSE) [31] was initially designed to measure empathy in medical students during physician-patient interactions (S-Version). The scale was developed following an extensive review of the existing literature, along with pilot studies involving physicians, students, and residents. One of the three versions of the scale is tailored for physicians and other healthcare professionals (HP-Version). This version focuses on the empathic behavior of clinicians during patient encounters. The scale consists of 20 items, with responses rated on a seven-point Likert scale ranging from 1 ("strongly disagree") to 7 ("strongly agree"). The total score can range from 20 to 140, with higher values indicating a higher degree of empathy. The scale demonstrates a high level of validity and reliability.

Scale of Ethnocultural Empathy

The Scale of Ethnocultural Empathy (SEE) [22] was used to assess ethnocultural empathy. This scale consists of 31 items and is completed using a six-point Likert scale (from 1 "Strongly Disagree" to 6 "Strongly Agree"). The scale comprises four subscales, with higher scores indicating higher levels of ethnocultural empathy. The scale demonstrates high internal validity and test-retest reliability. All three factors have a reliability index above 0.850, indicating a high level of reliability for each (general empathy $\alpha = 0.880$, clinical empathy $\alpha = 0.931$, and ethnocultural empathy $\alpha = 0.936$).

Sociodemographics

The final part of the research package consisted of a questionnaire focused on the sociodemographic characteristics of the sample. Specifically, participants were asked to provide information regarding their gender, age, marital status, profession, education level, foreign language proficiency, country of undergraduate/postgraduate studies, and experience living in a foreign cultural environment.

Data analysis

The analysis and presentation of results were conducted using SPSS Statistics for Windows, Version 26.0. For the description of quantitative variables, the mean and standard deviation (SD) were used, along with the median and interquartile range, following a normality check of the distribution via the Kolmogorov-Smirnov test. For qualitative variables, absolute (N) and relative

frequencies (%) were applied. The Pearson correlation coefficient was used to test the relationship between two quantitative variables. Linear regression analysis with the stepwise inclusion-exclusion method (stepwise linear regression) was applied to identify independent factors associated with the variables under study, yielding dependency coefficients (β) and their standard errors (SE). All tests conducted were two-tailed, and statistical significance was set at α=0.05.

Ethical aspects

The link to the electronic questionnaire was accompanied by an announcement about the research. Interested participants were provided with detailed information on the purpose and characteristics of the study, participant rights, and the researcher's contact details for any questions or concerns. Participants were assured of the anonymity and confidentiality of their responses, as all collected data were anonymized and securely stored (using encryption protocols). Participation in the study was entirely voluntary, and participants could withdraw at any time without consequences. For this reason, researchers ensured that participants had the option to delete or skip questions or navigate back to previous sections of the questionnaire.

The present study adhered to the Declaration of Helsinki [32] and followed the principles set forth by the American Psychological Association [33] regarding research on human participants. The study was conducted in accordance with the Declaration of Helsinki and was approved by the Ethics Committee of the School of Social Sciences, Hellenic Open University.

RESULTS

The mean score for general empathy is 60.215 (Std. Deviation 18.208, Median 56.250, Minimum 20.313), the mean score for clinical empathy is 74.727 (Std. Deviation 16.670, Median 71.053, Minimum 39.474), and the mean score for ethnocultural empathy is 71.462 (Std. Deviation 17.797, Median 73.913, Minimum 7.609).

General empathy is moderately and positively correlated with clinical empathy and strongly and positively correlated with ethnocultural empathy. Clinical empathy is marginally strong and positively correlated with ethnocultural empathy (see Table 1).

Table 1. Correlations between General, Clinical, and Ethnocultural Empathy.

		Clinical Empathy	*Ethnocultural Empathy*
General Empathy	Pearson Correlation	.576	.622
	Sig. (2-tailed)	.000	.000
	N	.106	.106
Clinical Empathy	Pearson Correlation		.594
	Sig. (2-tailed)		.000
	N		.106

With respect to the sociodemographic characteristics of the sample, the following correlations are observed.

General Empathy

General Empathy is correlated with participants' education level (P=0.000), foreign language proficiency (P=0.003), country of undergraduate studies (P=0.039), country of postgraduate studies (P=0.008), experience living abroad (P=0.001), and professional role (P=0.000). Specifically, the following patterns are observed:

a) As education level increases, general empathy also increases.

b) Individuals who speak languages other than Greek exhibit higher general empathy (mean = 62.035, SD = 18.094) compared to those who speak only Greek (mean = 45.964, SD = 12.111).

c) Participants who completed their undergraduate studies in Greece show a lower mean general empathy (mean = 58.651, SD = 17.108) compared to those who studied abroad (mean = 73.722, SD = 22.489).

d) Those who completed postgraduate studies abroad have higher general empathy (mean = 77.778, SD = 21.220) than those who did not (mean = 58.586, SD = 17.131).

e) Individuals who have lived outside Greece exhibit higher general empathy (mean = 70.257, SD = 18.877) than those who have not (mean = 56.611, SD = 16.652).

f) Physicians display higher general empathy (mean = 70.898, SD = 20.625) compared to nurses (mean = 55.595, SD = 14.985).

Clinical Empathy

Clinical Empathy is correlated with age (P=0.041), marital status (P=0.037), education level (P=0.000), foreign language proficiency (P=0.002), country of undergraduate studies (P=0.001), country of postgraduate studies (P=0.003), experience living abroad (P=0.000), and professional role (P=0.009). Specifically:

a) As age increases, the mean score of clinical empathy decreases.

b) Single individuals show the highest clinical empathy, with a mean score of 79.217 (SD = 15.295), while married individuals have a mean score of 73.634 (SD = 17.890). Finally, divorced individuals have the lowest mean clinical empathy score, at 66.842 (SD = 12.495).

c) Higher education levels are associated with higher clinical empathy.

d) Those who speak languages other than Greek have higher clinical empathy (mean = 76.456, SD = 16.632) compared to those who speak only Greek (mean = 61.184, SD = 9.397).

e) Individuals who completed their undergraduate studies in Greece have a lower mean clinical empathy (mean = 72.825, SD = 16.238) compared to those who studied abroad (mean = 91.148, SD = 10.412).

f) Those who completed postgraduate studies abroad show higher clinical empathy (mean = 91.813, SD = 14.500) than those who did not (mean = 73.142, SD = 16.016).

g) Individuals who have lived outside Greece exhibit higher clinical empathy (mean = 86.278, SD = 15.583) compared to those who have not (mean = 70.580, SD = 15.095).

h) Physicians demonstrate higher clinical empathy (mean = 80.592, SD = 16.356) than nurses (mean = 72.191, SD = 16.263).

Ethnocultural Empathy

Ethnocultural Empathy is correlated with education level (P=0.001), foreign language proficiency (P=0.002), undergraduate studies abroad (P=0.031), postgraduate studies abroad (P=0.011), and experience living abroad (P=0.012). Specifically:

a) Higher education levels are associated with increased ethnocultural empathy.

b) Individuals who speak foreign languages exhibit higher ethnocultural empathy (mean = 73.161, SD = 17.426) compared to those who speak only Greek (mean = 58.152, SD = 15.431).

c) Participants who completed their undergraduate studies in Greece have a lower mean ethnocultural empathy (mean = 70.297, SD = 17.842) compared to those who studied abroad (mean = 81.522, SD = 14.469).

d) Those who completed postgraduate studies abroad show higher ethnocultural empathy (mean = 83.816, SD = 15.299) than those who did not (mean = 70.316, SD = 17.644).

e) Individuals who have lived outside Greece exhibit higher ethnocultural empathy (mean = 76.786, SD = 18.890) compared to those who have not (mean = 69.551, SD = 17.112).

DISCUSSION

The results of this study provide valuable insights into the interrelationships of general, clinical, and ethnocultural empathy among healthcare professionals. The healthcare professionals participating in the study exhibit high levels across all three types of empathy, suggesting a robust foundation of empathetic engagement within this group, which is essential for patient-centered care in increasingly multicultural healthcare settings.

The three types of empathy examined interact and positively influence one another, meaning that an increase in one type of empathy leads to an increase in the others. This interconnectedness highlights the comprehensive nature of empathy as a multidimensional (rather than unidimensional) construct, where a foundation in general empathy enhances both clinical and ethnocultural empathy. Rasoal et al. [20,21] demonstrated that general empathy and ethnocultural empathy are correlated and share largely similar predictors. Similarly, Luna et al. [34] found an association between general

empathy and medical empathy. To our knowledge, this is the first study to explore the association between general, clinical, and ethnocultural empathy.

Sociodemographic factors, such as education level, foreign language proficiency, and experience abroad—through undergraduate/postgraduate studies or living abroad—were positively correlated with all three empathy types.

Education level emerged as a particularly significant factor associated with higher empathy across all dimensions. This finding is inconsistent with the study by Roger et al. [35], which found no association between empathy and education level among nurses. This is in line with a previous study involving 438 nurses which demonstrated that higher education levels and specialized training are significantly associated with compassionate care and capacity for empathy. On the contrary, this inconsistency could be explained by cultural factors, as the study by Roger et al. was conducted in Pakistan. Additionally, while the sample in Roger et al.'s study consisted solely of nurses, our sample included both medical and paramedical staff.

Both direct exposure to the "foreign" (studies and residence abroad) and indirect exposure (through learning foreign languages) positively contribute to the development of empathy across general, clinical, and ethnocultural domains. This finding aligns with Allport's [36] contact hypothesis, which proposes that intergroup contact facilitates understanding and reduces prejudice by allowing ingroup members to learn about and empathize with outgroup members. Direct intercultural experiences and language skills thus play a critical role in fostering empathy, reducing stereotypes, and promoting positive intergroup attitudes. Numerous studies [37, 38] focused on teaching staff, especially foreign language educators, demonstrate that study abroad programs enhance empathy and cultural awareness. However, similar research has not been conducted with healthcare providers. Additionally, findings suggest that empathy plays a central role in understanding language, people, and culture. Steffanell et al. [39] found that experiencing the perspective of a non-native speaker allowed Lee University students to empathize more deeply by putting themselves in another person's position. Similarly, in a language project with medical students it was argued that the foreign language learning environment, typified by it linguistic nuances and ambiguities and ongoing meaning negotiation, provides an ideal context for cultivating awareness of culturally shaped perceptions of the human body in healthcare settings [40].

These common factors suggest that the three empathy dimensions, while distinct, may be interconnected in their formation. Experiences that increase openness to diverse perspectives and improve understanding of others may lay a shared foundation for the development of general, clinical, and ethnocultural empathy.

Furthermore, general and clinical empathy levels were higher among physicians compared to nurses, potentially due to role-specific demands and the nature of physician-patient interactions, which place a strong emphasis on empathy in clinical practice (e.g., decision-making, medication adherence). This finding is consistent with the study by He et al. [41], which demonstrated that nurses had significantly lower empathy scores than physicians and other allied health professionals.

Finaly, clinical empathy was also higher among younger and single healthcare professionals, which may reflect the impact of professional burnout or personal life demands on empathy levels in older and married individuals. However, both findings are inconsistent with the systematic review by Maximiano-Barreto et al. [42], which identified factors associated with higher empathy as being older and married. Maximiano-Barreto et al.'s findings perhaps reflect the greater life experience and emotional maturity that come with age and parenthood.

Clinical implications

The findings of this study highlight the importance of fostering empathy—general, clinical, and ethnocultural—among healthcare professionals to improve patient outcomes and promote a culturally inclusive healthcare environment. High levels of clinical empathy can enhance patient satisfaction, trust, and adherence to treatment, leading to better health outcomes [8,13,43]. Ethnocultural empathy, in particular, is essential for navigating cultural differences and providing respectful, personalized care to patients from diverse backgrounds [44]. Integrating empathy training

into healthcare education, focusing on both clinical and ethnocultural dimensions, can prepare professionals to engage with patients empathetically and build therapeutic alliances across cultural boundaries [44,45]. Despite the limitations and reservations that have been expressed regarding the impact and the sustained effect of communication training on the enhancement of empathy [46], there is evidence that targeted educational interventions with healthcare providers and medical students can substantially improve physicians' empathic engagement with patients and medical students' empathy [47-49].

Additionally, healthcare institutions should consider policies that support ongoing professional development in empathy skills, including intercultural training and opportunities for professional exchange programs, which may help sustain empathy and reduce burnout by equipping professionals with strategies to manage emotional demands. Moreover, medical units should offer healthcare staff opportunities to learn foreign languages and establish exchange programs with medical units abroad. These programs can provide healthcare professionals with valuable experience working temporarily in foreign healthcare settings, thereby enhancing their ethnocultural empathy and overall effectiveness in multilingual and multicultural healthcare environments [50]. Medical schools can further support this by incorporating foreign language courses into their curricula, equipping future healthcare providers with essential communication skills for diverse patient populations. Also, empathy training should be integrated throughout the curriculum, bridging the gap between biomedicine and humanities [51]. Fleming et al. [52] show that targeted interventions in healthcare students can be effective. Similarly, Fragkos & Crampton [17] indicate that despite heterogeneity and biases, empathy interventions in medical students are effective.

Limitations

This study has some limitations. Specifically, it did not examine important factors such as student mobility through the Erasmus program and recreational travel. These factors can significantly impact individuals' cultural sensitivity and empathy, and their absence from the analysis may limit the generalizability of the findings. Additionally, the sample of physicians participating in the study was small, which limits the ability to draw robust and generalizable conclusions regarding this group of healthcare professionals. Furthermore, the sample of individuals with intercultural experience, such as studying or living in foreign countries, was also small. Future research efforts could enhance the validity and reliability of the findings presented here by including larger and more diverse samples and exploring additional factors.

Future research suggestions

Future research should expand on this study by examining additional factors, such as participation in student mobility programs (e.g., Erasmus) and recreational travel, could offer further insights into how intercultural exposure influences empathy. Longitudinal studies observing empathy development over time would provide valuable data on how empathy evolves through professional and cultural experiences. Additionally, developing and testing targeted empathy training interventions within healthcare education curricula could clarify the effectiveness of such programs in fostering empathy, particularly ethnocultural empathy. Research exploring the mechanisms of intergroup contact, as posited by Allport's contact hypothesis, may reveal how different types of interactions, like extended residence abroad versus short-term visits, differentially affect empathy dimensions. Finally, future studies could investigate the practical outcomes of empathy on patient care, examining how general, clinical, and ethnocultural empathy impact patient satisfaction, adherence, and health outcomes, especially in multicultural contexts. Addressing these areas will enhance our understanding of empathy in healthcare and guide the integration of empathy-promoting practices in diverse clinical settings.

CONCLUSIONS

Empathy is a multifaceted construct that plays a crucial role across various domains, including general interpersonal interactions and relationships, the clinical setting, and multicultural communities. Understanding the connections between general empathy, clinical empathy, and ethnocultural empathy is essential for holistically addressing diverse needs in both personal and

professional relationships. The integration of these three forms of empathy highlights the comprehensive nature of empathetic engagement. General empathy serves as the foundation upon which both clinical and ethnocultural empathy are built.

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