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REFLECTIONS

Empathy across cultures – one size does not fit all: from the ego-logical to the eco-logical of relational empathy

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Abstract
Empathy is extolled in Western healthcare and medical education as an exemplary quality to cultivate in trainees and providers. Yet it remains an elusive and inadequately understood attribute. It posits a "one size fits all" unidimensional attribute applicable across contexts with scant attention given to its multifaceted dimensions in intercultural contexts. In this article, we uncloak the shortcomings of this conventional empathy in intercultural settings, and instead propound an expanded "relational empathy".

Keywords Relational empathy · Intercultural empathy · Empathy disjunction · Cultural and epistemic humility · Cultural competence and capability

We describe the individualist Western construct of empathy as deriving from high income (often colonial) countries and we challenge (with case examples) its adequacy in intercultural collectivist settings of low-and middle-income countries. Here, it often lacks empathic accuracy and can provoke empathic dissonance and disjunction. We question the viability of cultural competence in navigating cultures and proffer instead *cultural capability* as a sensibility for ongoing improvement attained through cultural immersion. We examine power asymmetries; the bias of "othering;" and the impact of high-and low context communication on empathy expression in intercultural settings.

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We argue for a paradigmatic shift in empathy from the *ego-logical* (individualistic) towards the *eco-logical* (contextual and distributed) of relational consciousness. Relational empathy is construed as dynamically attentive to contexts; as co-adaptively engaging with the 'other' in co-creation of understanding and meaning through curiosity, sensitivity, and epistemic humility; and as democratizing power dynamics.

Given the increasing cultural diversity of patients and global interconnectedness wrought through socio-political upheaval, migration, climate change and the pandemic, we propose a more tenable model for reconnecting humanity through relational empathy.

> "*Empathy. . .is by nature multidimensional, interpersonal, and modulated by context.*" Decety (2020).

> "*Treating empathy simply as a skill or competency is unrealistic. Relational empathy … cultivated in a variety of social contexts, can enhance both intercultural understanding and commitment to social justice on the individual level.*" DeTurk (2001).

A UK medical school recently set up a programme to offer clinical education expertise to a resource-impoverished medical school in Ethiopia (Marshall, 2020). Part of that ongoing programme is to establish the medical humanities within the Ethiopian school's curriculum. The Ethiopian medical students are particularly interested in dance and drama, and a group of them wrote and performed a play with the theme "from rags to riches". Here, a young man is born into poverty to a single mother, but he achieves wealth and status through study and hard work (valued attributes not just in Ethiopia but across global medical school cultures). The story of the young man's conception is told in the play. He is a child born of rape. One of the visiting UK consultant doctors, in the audience, takes up the story:

> A wealthy man enters, spots her (the mother), drags her into the bushes off-stage and, from noises off, we are clearly to understand that he rapes her. He returns on stage, buttoning his flies and goes off the other side; she staggers back on and exits at the back of the stage, allowing us to see that the back of her dress is covered in blood. … What amazes us Brits about this performance is how amused the audience is by the rape; there are smiles and chuckles as the rapist returns to the stage, reaching a crescendo as we see the woman's bloodstained dress. This is not a gender-related issue as most of the audience is young women; nor is it age-related as the elderly academic next to me and another teacher are chuckling away. What can have been funny about the scene? … I could see the reaction of our own (UK) students … of shock and disbelief (ibid.).

Empathic dissonance and disjunction

Should these Ethiopian medical students and faculty be judged as morally underdeveloped or undisciplined? And of what use is empathy in this context if it reaches only to the level of pity in judging this audience as morally inept? Certainly, what is described here from

the uncomfortable point of view of the visiting UK audience is what we call intercultural "empathy disjunction", evinced in a kind of disbelief, squirming and emotional discomfort. Where "empathy dissonance" has been described as "the mental discomfort created by making expressions of empathy that are not sincerely felt" (Laughy et al., 2020), here we mean the opposite, where the empathy tap is turned up high. From such an intense level of identification with the scenario, one feels disjunction between one's own authentic feelings and thoughts about a situation and the actions of others – perceived as casual - that seem to discount such empathic engagement.

Throughout this article we provide illustrative examples of empathy disjunction or empathy dissonance sourced from the literature backed up by our own experiences. We are aware that such empathy disjunctions and dissonances can quite readily occur as intra-cultural rather than inter-cultural phenomena, but here we focus on the inter-cultural where issues such as neo-colonialism or imperialism within healthcare education are causes for concern (Bleakley et al., 2011).

Empathy, generally described as an individual psychological state of identification with another, can be framed as a dynamic social interaction where empathy is not "in" the individual but is a product of the quality of social interaction, and so is "in" the social exchange. Empathy can be viewed as a discourse open to cultural and historical inflections, or is contextual and situated (Bell, 2013; savageminds.org). What is considered normative in one culture (for example, direct eye contact in a North American setting) is not normative to another culture (for example, prolonged, direct eye contact is considered rude In Japan) (Bleakley et al., 2011). And contexts change, often dramatically, through history (for example, in all-male North American medical schools in the early 20th century it would not have been unusual for cadavers for dissection in anatomy classes to be black persons, and, shockingly, for the white students to openly make jokes about the cadaver and be photographed with it in mocking poses – an extreme form of empathy dissonance (Bleakley, 2020)).

Empathy, regarded as central to effective clinical practice, is often treated as transparent and uncontested – read as a universal human condition. However, empathy is both a historically- and culturally-situated notion. We cannot assume that "one empathy fits all" (Bleakley, 2014). When empathy is defined as understanding the thoughts and feelings of others *in their cultural context*, empathy may be pointing in the direction of universal elements. However, this definition may complexify a host of studies that show how empathy engenders trust between patients and health workers, and often leads to better clinical outcomes, that were solely conducted in Western countries (Howick et al., 2018; Decety, 2020; Ekland and Meranius, 2021). We must ask: which culture's empathy is at work here? Moreover, does it matter? Well, yes, it does matter if you cross cultures and find either empathy disjunction or dissonance at work in terms of differing understandings of "empathy".

Indeed, empathy is also intra-culturally modulated. Within North American culture, reading fiction has been shown to increase empathy (through identification with characters) thus showing an intra-cultural dimension to education of empathy (Bleakley, 2014). Again, "one-size" empathy does not fit all, both across and within cultures. Furthermore, the widely accepted conclusion that "empathy decline" is characteristic of medical education (Hojat et al., 2009; Bleakley, 2015) – is based on medical students' responses to largely culturally specific empathy scales. (We are aware that use of the JSE scale is not restricted to North American cultures, but studies have been made in lower resource environments such as South Africa (Archer & Turner, 2019). However, such studies are uncommon).

"Empathy" did not enter the English language until 1909, when it was first coined by the German psychologist Titchener to refer to an aesthetic state of *appreciation* of another's feeling states. The ancient Greeks had long used the term "pity" to describe a range of feelings concerning identification with another (Marshall & Bleakley, 2017). Further, where "empathy" was rapidly identified with an individual's inner state, "pity" was used to describe a state of immersive engagement with those around. This is what has become known (with nuances) as social, distributed, collective, or relational empathy (ibid.). This approach describes an action (a verb), and not a thing (a noun), that is eco-logical, public, or worldly rather than ego-logical or private. This view, of course, is contestable.

Eco-logical rather than ego-logical empathy

Anthropological studies show differing understanding and expression of empathy (Hollan & Throop, 2011). Yet many researchers seek global consensus definitions of empathy as a unit, even while several facets may be recognized. The problem here is that such researchers are characteristically from the Western/ Northern hemisphere High-Income Countries (HICs) elite, as opposed to Low- and Middle-Income Countries (LMICs), and can be seen to conspire towards a neo-colonialism (Abimbola and Pia, 2020; Richardson 2020). My empathy becomes yours, not by choice but by design.

Empathy, as most recently conceptualized and studied in dominant culture research settings, includes cognitive and motivational dimensions, and self-other distinction of emotions achieved by emotion regulation (Decety, 2020). *Affective empathy* involves the capacity to perceive and identify with the emotional experiences of another, such as instantaneous caring responses to another's suffering. *Cognitive empathy* refers to rational understanding of the perspective of another - the dimension of empathy typically promoted in healthcare settings. The *motivational* dimension to empathy (also called *empathic concern*) is the desire to act in the interest of another's welfare, based on shared affects and understanding of another's perspective and situation. Finally, self-other distinction enables *emotion regulation* and entails the ability to mitigate or control emotional responses, freeing up the cognitive resources that sustain flexibility and attention to another's experience while minimizing personal distress (Ekland and Meranius, 2021).

Neuroscience research has elucidated the different brain networks involved in affective, cognitive, and motivational dimensions of empathy, and in self-other distinction (Decety & Jackson, 2004; Decety and Ikes, 2009; Riess 2010, Riess et al., 2011, Riess, 2011, Riess et al., 2012; Engen & Singer, 2013; Riess, 2018). However, these studies have been conducted in predominantly Western/Northern Hemisphere countries, although they include multicultural participants. There is an urgent need to expand such research to non-Western/ Northern Hemisphere cultures to avoid culturally specific conclusions. While such neuroscientific examinations of empathy are laudable, they leave us with the thorny question of cultural variations and their implications for cross-cultural teamwork. Our focus here is neither empathy in the brain nor empathy as individual psychology, but empathy as a cultural phenomenon.

Withheld empathy, an accomplice to social harm?

Whereas studies suggest that empathy can strengthen therapeutic relationships with patients, improve clinical outcomes, mitigate burnout, and even reduce risks of litigation against healthcare workers (Riess, 2010; Gleichgerrcht & Decety, 2013; Howick et al., 2018), we must ask in which cultural contexts are these observations being made? And what if a healthcare worker wants to explicitly display empathy but senses that it is not culturally appropriate? This conjures an empathy about empathy, a meta-empathy, where such binds again create empathy disjunction. Consider the following dilemma of an American trainee working in Ghana (Abedini, 2015). The patient is a young mother whose healthy newborn has just died. The mother is disconsolate, wailing in grief, while a nurse berates her. In the trainee's words:

> I reached out to touch her arm—to comfort her—but I suddenly recoiled at the sight of my pale hand. . My skin color and Western upbringing afforded me an uncomfortable level of influence and constant scrutiny. Any action on my part, while perhaps temporarily quelling my own desire to provide comfort … could potentially be construed as intrusive and condescending. I was suddenly fearful of the consequences that could come from my interference and thus remained silent.
> My inaction made me feel like an accomplice to social injustice …. I hated the providers who behaved in ways that I believed were fundamentally at odds with our professional obligation as healers, I hated the culture that condoned such dispassionate behaviors …. And, oh, how I hated myself. (ibid.)

While we cannot presume to know the patient's perspective in this interaction, the trainee thought her intended actions might be misunderstood. Her dismay and perceived failure to respond caused her moral distress, creating cognitive and emotional disjunction. This is not empathic dissonance, because her feelings are genuine. We are again in the territory of meta-empathy, acting as superego or conscience. She felt she had failed both herself and the patient. We might, however, say that she failed to engage in a more culturally sensitive approach to empathy to better deal with the situation. This, we suggest, highlights the need for global health practitioners and providers working in inter-cultural settings generally to know about themselves and their host cultures to effectively manage these multifarious emotional responses as a key aspect of care.

"Empathic accuracy" (Zaki et al., 2008) relies on appropriate interpretation of the presumed experience of another in its specific context. Could a medical student, doctor or other healthcare worker then move seamlessly from Canada to Bhutan without breaking sweat? We saw above that empathy transference is not predictable. And here is a key to empathy transfer: the metaphor. Does "without breaking sweat", or a host of other metaphors common in Canadian conversation, grease the wheel of empathy in Bhutan, Nigeria or the Philippines? This metaphor translation is not just about travelling between countries, for the migrant crisis has brought potential empathy disjunction and dissonance to doorsteps in Europe and North America: for instance, as a refugee and stateless person from Cameroon is treated by a medical team in Paris or Vancouver, with language and symbol barriers that bear down on the slight bridge that is empathic concern. The cross-cultural language disjunction has been the subject of years of research on why patients feel uncomfortable at the

hands of medical paternalism within their own culture, where medical lingo is not understood by the patient, who is excluded or made to feel inferior (Bleakley, 2021).

An additional example of empathy disjunction was revealed during an empathy reflection exercise that was part of a randomized controlled trial of empathy education in the United States (Riess et al., 2012). This reflection was shared by a Western/Northern Hemisphere-trained OB/GYN resident, born in the US of South Asian heritage, who reported having a lack of empathy during a scheduled prenatal visit with a couple from the Middle East. She recoiled internally when the husband answered every question posed to his wife, who sat in silence with no discernable facial expression and uttered no words for the entire visit. The resident "empathized" with the wife and her perception of dominance by her husband and felt anger toward the husband. Subsequently, as a result of participating in a discussion of relational empathy, she realized she did not understand the couple's cultural norms and had not engaged her own curiosity to learn about the norms she had witnessed. Rather, she had projected her own feelings of disgust in her interpretation of the norm as dominance of women by men, and focused on how she would have felt had she been silenced by a male, rather than understand the interaction from a multicultural perspective. By sharing this experience, the resident and other participants in the study learned the value of shifting from an ego-logical perspective to an eco-logical and intercultural empathy perspective.

Towards a relational empathy

What does all the above mean in practice? How might we remedy such situations? How do we avoid cultural minimization (Bennett, 2017), the blindness of privilege, and symbolic violence (Bourdieu, 1998) as a product of dominant culture impulses? How do we temper empathy disjunction and counter dissonance? We will consider several active approaches to intercultural empathy, as: intercultural sensitivity, cultural competence extended to cultural capability, high and low context communication, "othering", and cultural and epistemic humility. All of these are grounded in power differentials, and all share strong similarities, together constituting "relational empathy." This cluster of notions are seen to shelter under a more encompassing will to democracy.

Intercultural empathy

Barron (2020) describes intercultural empathy in the context of pedagogy as "placing oneself in the cultural background of another" and then being able to effectively communicate that empathic understanding. Rettig (2017) sees three dimensions to such empathy, noted earlier: cognitive (knowledge), affective (emotional engagement) and behavioural (acting in an empathic manner). Trevisani (2020) adds a fourth component: "relational empathy," the understanding and appreciation of the symbolic network of people who are close to the person with whom one is empathizing. Registers and nuances of contact are key. For example, Lorié and colleagues (2017) studied cross-cultural nonverbal and semiotic expressions of empathy and identified how, in clinical settings, physical gestures and facial expressions varied with culture, race, gender and occupation. Certain gestures appear to be universally appreciated, such as an open body posture, smiling, and warm facial expressions. Another study (Riess & Kraft-Todd, 2014) revealed that nonverbal behaviors, such as closed body

postures, unequal eye level, physical barriers between healthcare provider and patients and certain hand gestures, may signal disrespect. Kelly and colleagues (2020) have drawn attention to the complex cultural and situational interpretations of touch in clinical encounters. Importantly, given these and other differences in communication styles, providers working in global health and other intercultural settings could fail to observe and misconstrue both the empathic gestures of others and how their own gestures are interpreted (Zhu, 2011).

Intercultural sensitivity

Bennett (2017) identifies six increasingly complex stages to acquiring "intercultural sensitivity," starting with an appreciation of one's own culture and progressing towards the conscious embrace of other cultural norms and perspectives. Empathy emerges in this context as a form of intentional perspective-taking, strengthening communication and building relationships. Curiosity and a willingness to learn the norms of empathic expressions in other cultures are essential for expressing empathy accurately (Rettig, 2017). The effort to foster empathy also entails other attributes, such as humility, curiosity, open-mindedness, and emotional regulation.

Consider the following hypothetical case involving a medical trainee from a high-income country visiting a clinic in a low-income country (this case is based on one author's experience and observations):

> Sue is an American fourth-year medical student on a month-long rotation at a rural clinic in a tropical low-income country. She is with a team seeing women with advanced pregnancies. The mothers are unaccompanied and appear unsmiling, the nurses brusque and the physicians fast-moving, giving orders with no discussion. Sue cannot understand why no one seems happy about the women's pregnancies and why no warmth or interest is expressed for the young mothers. The experience leaves her feeling sad for the women and disappointed in the medical staff. She considers trying to find a way to bring some sense of joy and celebration to the expectant mothers.

Sue's reaction illustrates how prior knowledge, values, and experience shape interpretation even of novel situations; indeed as we daily seek to understand what we observe, our only tools are these pre-existing frameworks. Her limited understanding of childbirth informed her view of pregnancy as a generally joyous occasion, a time when expectant mothers are congratulated and health care providers engage warmly and positively with their patients. Her perspective neglected awareness that for women in low resource settings childbirth can be dangerous, and medical care inaccessible; care providers may be working under considerable stress, unable to provide optimal care; children may be unwanted and costly; the gender of a newborn may have differential social value; women may have limited reproductive choice; and in cultures in which stoicism is the norm, expressions of fear, joy, need, and compassion may be tempered. Sue's unfamiliarity with the culture, context, and personalities, coupled with the culture's view of childbirth and her confidence in her own judgment places her at risk of misinterpreting the situation and behaving ineptly, creating empathy disjunction. Her unease prompts her to want to "fix" the situation to generate experiences more congruent with her own. And this is surely the key issue: empathy is not about *assimi-*

lation of another's world into one's own world view. It is about *accommodation to* the other. Again, ecological (embracing context) and not ego-logical.

From cultural competence to cultural capability

Inter-cultural empathy and sensitivity are key dimensions to so-called "cultural competence," an idea that has been around for half a century. Actually, "competence" is not the best descriptor, having a literal meaning of "good enough" - cultural "capability" would be better (Stephenson, 1998), following the "capabilities" approach of Nussbaum (2011) and others. Capability suggests room for improvement, or a desire for innovation. DeTurk (2001), for example, smells a rat when it comes to easy prescriptions for cultural competence, insisting that, "the very notion of cultural competencies … has been challenged in the context of power relations among communicators," and that cultural competence falsely "assumes the value of open communication with the aim of mutual understanding."

Whether intercultural empathy can be fostered through teaching cultural competence is debatable without an experience of deep immersion in another culture. Indeed, some educators have disputed the effectiveness of competency-based medical education generally, especially when disconnected from cultural contexts (Kumagai & Lypson, 2009; Lingard & Hodges, 2014; Kumagai, 2014; Eichbaum, 2015, 2017). Arguments against competencies include their often reductionistic formulation that can gloss over complexities of human cognition and behavior, returning to the value of "capability" above. Kumagai (2014) warns that competencies may threaten to "reduce the profound, complex human values and interactions inherent in the act of healing into … fragmented behaviors robbed of context," while Wear & Zarconi (2011) insist that certain areas of medical education involving imagination, curiosity and reflectiveness should be off limits to the "competency gaze." Kumagai & Lypson (2009) pithily put it: "Cultural competency is not an abdominal exam." The more complex form of cultural capability (Nussbaum, 2011) - a deep sensitivity to a culture that becomes a sensibility, or unique way of perceiving - can likely be attained through prolonged immersion in a culture, but the extent to which it can be didactically taught, observed and assessed without such immersion is deserving of further study and debate. Here, anthropologists and ethnographers must aid medical and health care educationalists.

Some de-emphasize the importance of culture, arguing for more commonalities than differences, that Bennett (2017) terms "cultural minimization." In global health, cultural minimization has become of heightened relevance in the current intensive move towards "decolonization" (Abimbola & Pai, 2020; Abimbola et al., 2021; Eichbaum et al., 2021). It perpetuates the mindset of "coloniality" (Richardson, 2020) and its associated power relations by promoting the "continued operation of dominant culture privilege" (Bennett, 2017). Such power dynamics, as we argue below, can interfere with culturally sensitive and socially aware empathy.

High and low context communication: power asymmetries

Hall (1997) draws a distinction between "low-context" and "high-context" cultures. Low-context cultures (such as that of the United States) expect communication to be unambiguous and explicit. In contrast, in high-context cultures (many Asian and African countries), "messages are conveyed implicitly, requiring the listener to read between the lines," where

"good communication is subtle, layered and may depend on copious subtext" (Kumagai & Lypson, 2009), including indirection and subtlety. If empathy and cultural competence are "interwoven and mutually reinforcing," as Kodjo (2009) and Zarei and colleagues (2019) insist, and communication plays an important role in empathy, differences in the openness of communication would impact the expression of empathy. Thus, a healthcare provider from a low-context culture could, with the best of intentions, communicate openly and with well-intended empathy in a manner that a patient from a higher-context culture may misinterpret and could find awkward, if not unsettling. For example, to return to a previous example, it is well documented that while maintaining eye contact is central to communication (and generating empathy) in North American and European cultures, it is considered offensive in Japanese culture (Uono & Hietanen, 2015).

Visitors from HICs may then assume the value of "open" and explicit communication, whereas those in low resource settings may submissively assume more implicit forms of communication. What Virchow termed "the blindness of privilege," Bourdieu (1998) describes as a form of "symbolic violence." In many traditional health care settings, sovereign power differentials are implicitly accepted in the command hierarchies of clinical practice (Bleakley, 2021), paving the way for the habitual exercise of authority by visitors from HICs. The exercise of sovereign power can however diminish an individual's ability to empathize, read emotions, and adapt behaviours to other individuals. However, as Foucault (2008) has shown, power is not just sovereign (power over) but also capillary (power runs through all systems and can be harnessed as forms of resistance). In a neo-colonial situation, expressly inauthentic empathy can act as a form of resistance on the part of the oppressed, as "sly civility" (Bhabha, 1985), confounding even the well-intentioned and wide-eyed colonizer, and creating murky waters where varieties of authentic, disjunctive and dissonant empathy interact. This cries out for closer examination through research.

The case of Sue (above) exemplifies "othering" and sovereign power dynamics that interfere with development of an empathic relationship. Confident in her belief that "best care" means taking time to celebrate each birth, Sue feels the local providers are failing their patients by not expressing their joy for each pregnancy. Her presumed position of power and privilege motivates her to impose her own understanding of good care on the experienced practitioners and to attempt to "fix" the situation in actionable ways. Studies in implicit bias (Greenwald & Krieger, 2006) suggest how power differentials and assumptions of superiority are insidiously reinforced and lead to inept behaviors such as stereotyping and blunted empathy. But what we don't know is what the local providers felt about Sue, and what forms of empathy they employed. However, we are also aware that health care systems in under-resourced settings are under pressure, where workers may deliver what is perceived as sub-optimal care not because they choose to, but because of the conditions that they work under.

Cultural humility and epistemic humility

Cultural humility is an attribute that may help providers working in intercultural settings to cope with challenging situations (Tervalon & Murray-Garcia, 1998; Haggard et al., 2018; Van Tongeren et al., 2019). Humility, as an acknowledgement of trainees' personal biases and limitations, may serve to temper their expectations and encourage open-minded learning. Visiting HICs providers cannot assume a full understanding of the cultural behaviours and norms they witness, but some suggest that cultural humility may help them to navigate

challenging situations. However, such providers should understand that cultural humility is mostly a cognitive attribute distinct from the affective expression of humility. Patients and healthcare workers in some cultures may misinterpret expressions of humility as a lack of knowledge and/or confidence to make effective decisions, and they may feel "safer" with, for example, an apparently confident and paternalistic physician.

"Epistemic humility" (Matthews, 2006) describes humility towards other knowledge systems, indigenous knowledge, and "different ways of knowing" (Kumagai, 2014). Epistemic humility has particular relevance to empathic encounters between providers from HICs (who may assume the superiority of Western science and medicine) and individuals from LMICs, especially in settings fraught with "coloniality." Richardson (2020) defines coloniality as "the matrix of power relations that persistently manifests transnationally and intersubjectively despite a former colony's achievement of nationhood." Such matrices of power relations still predominate in many intercultural and global health settings. Being open to indigenous knowledge and amenable to other ways of knowing also mitigates proclivities towards "othering" (see below) and assumptions of knowledge superiority that can intrude on, and impede, empathy. And this works intra-culturally too. For example, mentioning the importance of aesthetic dimensions - such as "beauty" and a "poetic imagination" - to hard-nosed pragmatic clinicians can raise a smirk and barely disguised laughter. Yet is a medicine and healthcare of qualities not just as important as one of measurement and quantities, and can this not form a matrix for empathy?

Othering

A further difficulty inherent to global health and intercultural encounters is the risk of "othering," understood as the propensity to view an individual outside one's own social group as different, alien, or other in a negative sense (Shapiro, 2008). Othering and ethnic/racial/gender stereotyping close down empathy (Zahavi et al., 2011; Meconi et al., 2015). Othering reinforces power dynamics, as demonstrated in public policies that contribute to the ongoing oppression of minorities, specific ethnic groups, people of colour, specific gender identities, and maltreatment of asylum seekers, refugees, and immigrants. In healthcare, othering can foster varying degrees of dehumanization, such as enabling denials of care to individuals and populations different than the individual in power.

In intercultural settings, an insufficient grasp of local power dynamics, hierarchies, and othering can impair visiting providers' empathic capacities. Professional hierarchies and health systems may further impede trainees' capacities in intercultural empathy. Some cultures, especially in HICs, may not foster communication that strives towards mutual understanding, particularly in contexts characterized by high patient volumes, limited resources, rigid hierarchies, or other barriers to sustained communication. In such settings, empathy may be considered a lower priority among local medical staff and trainees in LMICs given the resource limitations and the exigencies of clinical care (Tavakol et al., 2012). Visiting providers working in such environments may then be challenged by both their own empathic deficiencies and by a perceived lack of empathy demonstrated by local physicians and patients' acceptance of this dynamic.

Relational empathy, curiosity, and epistemic humility

Now we are at the heart of the matter. Our discussion has brought us to "relational empathy" introduced above, and popularized by Trevisani (2020). As noted, the habitual ego-logical individualist approach to empathy fails to apprehend that empathy is fundamentally *relational* - rather than a personal "attribute" (affective, cognitive, or mixed). The notion of empathy as an individual attribute or skill the provider expresses toward the patient is unfamiliar and perplexing in collectivist cultures (Broome, 1981) instilled with "relational consciousness" (Richardson, 2020), as portrayed in the South African indigenous term *Ubuntu* - "a person is a person through other people" (Krog, 2012; Lama et al., 2016). In individualist empathy, the provider is said to "have empathy for" the patient but the patient's agency in the relationship is mostly disregarded. Alternatively, "empathy for" can be seen as intentional - an "ecological perception" framed by context (Gibson, 1975; Broome, 1981), De Turk (2001) and others call for a relational approach to empathy that entails a "co-directional" dynamic interplay between participants leading towards co-construction of a "shared world" of meanings. Studies examining empathy education that focus on perceiving, understanding and responding to the emotions of others with curiosity and humility have shown that empathy with others can be taught (Riess et al., 2011; Riess et al.,, 2012) and retained one year later (Phillips et al., 2013). Relational empathy is a form of contextual (Laughy et al., 2020), participatory (Broome, 1991), shared learning that occurs dynamically in the moment and likely improves with reflection on experience, as previous examples and commentary on our illustrative case studies suggest.

As Broome (ibid.) notes, in the course of a conversation and professional relationship we can, through "an infinite series of successive approximations," come closer to achieving shared understanding. This process of seeking mutual understanding requires curiosity and the elements of playfulness and tentativeness rather than "seeking certainty, closure and control" (Phillips et al., 2013). It requires attending to contexts and engaging with the other to achieve shared understanding in ways that currently evade ego-logical forms of empathy. Eco-logical, relational empathy acknowledges the gaps in understanding between the interlocutors and calls for inquiry that shows respect, concern, and investment in the other as a grasp of *situation*. It may also call for relating more broadly with curiosity and humility towards others in the wider healthcare setting to obtain shared understandings and meaning.

In Sue's situation (above) the practice of epistemic humility might have helped her to recognize that the norms with which she was familiar did not apply in the new context. Curiosity might have driven her to ask local nurses or physicians about the values informing their practices and the pressures (such as lack of resources) under which they work. Better, to facilitate relational rapport with patients, she might have listened intently to what they thought might be done to help them to take better care of themselves. In contrast, the American medical trainee in Ghana (above) appears to have a deeper sense of relational consciousness (Richardson, 2020). She knew her compassion was legitimate but that her emotions could be misconstrued. Curiosity, epistemic humility, and her consciousness of the culture she was immersed in, presumably led her to establish what more she needed to learn to attain a shared relational empathy. In each case, we suggest there may have been metaphor disjunction. In speech and activity, culturally-specific metaphors not only oil communication but also give heightened meanings to intensify exchanges. It is extremely

hard for inexperienced visitors to a culture to engage with these sophisticated levels of metaphorical exchange.

Much more research needs to be done to map out educational practices for intercultural empathy. Such research is best carried out in situ, on the job, as work-based learning. Certainly, curiosity is key to such practices as a "crucial metacognitive organizing theme for clinical empathy" (Halpern, 2012). In intercultural contexts, where providers need to be self-aware, respectful of, and sensitive to, different worldviews, curiosity is essential for the co-construction of the shared worlds that enable culturally sensitive empathic expression. Readers might check if such fostered curiosity is a common, stated or explicit learning outcome or competence in undergraduate medical education in their neck of the woods. We think not – it is usually assumed or held as implicit.

Conclusion: the road to democratizing

In intercultural settings where one culture has a colonial (or other) history of patronizing or oppression towards another, as well as in professions where hierarchy is pronounced (as in medicine), power dynamics grounded in such privilege may potentially interfere with the development of a *relationally* empathic connection. Democratizing medicine may be a prerequisite for a relational empathy that calls for an active *decentering* of both cultures and individuals from habitual stances (Bleakley, 2021). This may require *unlearning* of culturally dominant behaviours, leading to cultural biases (Nixon, 2019). But first, such biases have to be recognized, returning us to the project of democratizing medical and health cultures through education.

All of the above can be captured as aspects of medical and health care culture's greatest challenge – how to achieve democracy in the shadow of a historical legacy of individualism and authority-led hierarchies? How will authentic inter-professional teamwork and sensitivities to patients be achieved as a global concern? First, we must ask, reflexively, if democracy is another of HICs' neo-colonial gestures? But we refute this, as we include in democracy equity and equality of opportunity, or social justice. Democracy, grounded in hunter-gatherer collaboration, precedes colonization (Flannery & Marcus, 2012).

Ongoing systemic racism and the rise of protest movements such as Black Lives Matter in HICs, our ineluctable interconnectedness demonstrated by the Covid-19 pandemic, the climate crisis, and a host of intractable global political conflicts and inequities (including vaccine distribution), all suggest a need to reconsider how we productively relate to one another and how we revision personal empathy as intensive social collaboration. Here, we have highlighted certain limitations of the ego-logical individualist approach to empathy for healthcare providers in intercultural and global health settings. This approach permeates HICs and invites neo-colonialism in medical education. Noting that empathy can be seen as "multidimensional, interpersonal, and modulated by context" (Decety, 2020) we note that this model offers a productive alternative to individualism. Given the increasing cultural diversity of patient populations, increased by refugees crossing borders for political asylum, concerns about physician burnout, the ostensible decline in empathy among medical students, trainees and faculty, the time appears ripe to re-examine our current approach to empathy and to consider other models embracing difference and social distribution, such as relational empathy.

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