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Clinical empathy in medical consultations in Japan

An exploration of the medical education context*

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Abstract Extant research has provided evidence of a positive link between doctors' expressions of empathy and increased patient satisfaction with the quality of care (e.g. Hojat et al. 2010; Silverman, Kurtz, and Draper 2013). In the Japanese context, several studies have reported that Japanese doctors' expressions of empathy were extremely infrequent (e.g. Ishikawa et al. 2002a,b; Wheeler 2011) and that doctors are often described as being distant and that such attitudes towards patients commonly result in complaints from foreign residents of Japan. This study examines how and why the expression of empathy observed among Japanese doctors is so limited. A structured literature search of clinical communication skills textbooks and guidelines for the medical education context was undertaken. The review highlights the following three contributing factors: 1) clinical empathy, as a concept in clinical communication, remains reflective of the Western conceptions, and uncertainty lies behind the conceptualisation and definition of clinical empathy in the Japanese context; 2) most references to empathy in Japan are representative of Japanese doctors' listening style; 3) there is a notable lack of encouragement to elicit information (e.g. concerns, ideas, expectations) from patients.

1 Introduction

It has been half a century since the theoretical basis of doctor-patient communication came into focus in the 1960s. Scholars and educators came to believe that successful medical consultations could be achieved by understanding patients' concerns and feelings, which requires a degree of empathy (Northouse and Northouse 1997; Silverman, Kurtz, and Draper 2013). Different disciplinary approaches to empathy have yielded various definitions of the term. While the English word 'empathy' refers to one's ability to understand human emotions during interactions with others (Oxford Dictionaries 2015), Howe (2013)

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proposes that empathy also requires an active effort or a cognitive challenge. Studies have shown that empathy can be the dynamics at the heart of communication between people, and that it ultimately supports positive social interaction outcomes (Broome 1991; Davis 1994; Howe 2013).

The term *clinical empathy* is commonly used in medical care. Brugel, Postma-Nilsenova, and Tates (2015) provide that clinical empathy is a professional skill that doctors consciously use to achieve successful consultations. Clinical empathy comprises three elements: (1) *cognition*: the intellectual capacity to recognise and understand the patient's emotions; (2) *motivation*: the motivation to communicate this understanding; and (3) *behaviour*: the capacity to transfer this understanding through effective communication (Brugel, Postma-Nilsenova, and Tates 2015: 1261). Lawrence et al. (2004) summarise the concept of empathy defined in psychology, noting that two principal dimensions of empathy exist: *cognitive empathy* and *emotional empathy* (also called '*affective empathy*'). Emotional empathy can be divided further into two dimensions, *parallel* and *reactive* emotional empathy, the latter of which can be manifested in sympathy or compassion. Davis (1994) explains that empathy is the ability to sense people's feelings and views intellectually and to achieve an imaginative understanding, which is a truly empathic reaction. On the one hand, emotional empathy involves emotive responses to others with similar emotions, called *parallel emotional empathy*, while on the other hand, instant emotive responses to others with different emotions represent sympathy or compassion. Cognitive empathy alone is not adequate for sensing how another person reacts to and appreciates emotional connections in interpersonal relationships; this requires emotional empathy. Consequently, this might cause confusion regarding the definitions of empathy and sympathy. It is important to distinguish empathy from sympathy. Northouse and Northouse (1997: 24) describe sympathy as "concern, sorrow or pity shown by an individual for another individual. It is the expression of one's own feelings about another person's predicament and the urge to alleviate his or her suffering". Sympathy is used to signify the 'resonance' aspect of emotion and is viewed as containing elements that are passive in nature. In contrast, 'empathy' is believed to involve more active elements, such as making an effort to step outside the self (Davis 1994: 5).

Studies have provided evidence of a positive correlation between doctors' expressions of empathy and increased patient satisfaction with quality of care and recovery rates (Hojat et al. 2010; Silverman, Kurtz, and Draper 2013). However, disagreements have surfaced on demonstrating empathy to patients because in some cases, such as with acute care, doctors must make detached diagnoses that require keeping some level of professional distance between themselves and their patients (Washer 2009). To some degree, doctors must learn to hide their feelings from patients – usually an aspect of their education – which likely leads to more detached care (Colliver et al. 2010; Neumann et al. 2011; Pas-

salacqua and Segrin 2012). Unfortunately, empathy in medical students and residents is subject to decline over the course of their training (this will be further reviewed in Section 2.3). Furthermore, medical professionals need to operate in highly challenging circumstances – e.g. under heavy workloads and tight schedules – making it difficult for them to improve their empathic skills. Un-empathic medical professionals might neglect their patients' emotional cues and fail to achieve an understanding of their patients' situations, while over-detachment can lead to serious consequences for themselves in clinical practice (Buckman, Tulsky, and Rodin 2011; Faulkner 1998; Kerasidou and Horn 2016). Health system factors such as environment and waiting times also would need to be explored, along with relationships.

In Japan, doctors traditionally do not explain details in clinical settings, and patients tend to talk very little, rarely voicing their own feelings and concerns to their doctors (Yajima and Takayanagi 1998). Although patients are more informed than ever, most patients prefer to leave choices and important decisions to the professionals. Cultural studies have revealed that due to the social emphasis on group-oriented harmony over individual goals, the use of indirectness to reduce interpersonal friction and people's feelings of belonging to groups take precedence over their personal feelings (Barnlund 1989; Hofstede, Hofstede, and Minkov 2010). Wheeler (2011) claims that Japanese doctors are often described as being cold and distant, and that such unsympathetic attitudes towards patients commonly result in complaints from foreign residents in Japan. Studying this noticeable aspect of Japanese physician-patient consultation styles, Ishikawa et al. (2002a,b) report low scores on displays of empathy among Japanese physicians and that their expressions of empathy were extremely infrequent. Kataoka et al. (2009) examined differences in empathy scores among Japanese medical students in different years of study using psychometric measurements. The scores showed that overall female empathy levels were higher than male levels, and that the mean empathy scores increased from the first year to the last year of medical school. Furthermore, the principal elements of empathy, such as 'compassionate care', 'perspective-taking' and 'the ability to stand in a patient's shoes', were the same elements observed in U.S. and Mexican medical students. However, the mean score for the Japanese sample was lower than that for the U.S. and Mexican medical students. In an attempt to explain this lower mean score for the Japanese sample, medical education differences and differences in expressions of empathy were offered as explanations (Kataoka et al. 2009).

Specifically, science-oriented medical curricula, the different medical school admissions systems and Japanese patients' preferences for calm and unemotional clinicians are considered to be factors that potentially influence scores. In the present study, the principle objective will be to examine how and why the use of empathy observed among Japanese doctors is so limited. This objective will be accomplished by identifying how clinical empathy is conceptualised in the context of medical education, determining to what extent a

link exists between Japanese doctors' display of empathy and the medical school curricula. Through this, the present study will be able to identify the specific cultural communication style that emerges when Japanese doctors express empathy towards patients.

To achieve this, the present study conducted a structured literature review by considering the following research questions:

1. What is the nature of the existing consultation skills training and relevant examination in Japan?

2. Are any contextual barriers presenting that prevent Japanese doctors from showing empathy towards their patients?

This structured review was intended to identify the salient factors that affect clinical consultations in Japan and form the basis for promoting the use of clinical empathy in the current context of Japanese medical education. To address the first research question, the most widespread learning syllabi, educational guidelines and policy documents from Japanese medical institutions were chosen and used to confirm the educational textbooks' content referenced in medical interview skills training. The materials with the Japanese term *kyōkan* (empathy) in their content received particular attention. To answer the second research question, empirical studies conducted to assess empathy among Japanese medical students, residents and clinicians were reviewed. The article search was initiated in MEDLINE and *Ichushi-Web*. The focus was directed towards published papers that contain the term 'empathy' in their titles and abstracts and 'Japan' in their main text, and for Japanese articles, the Japanese term *kyōkan* (empathy) in their titles and abstracts. The search was restricted to these publications to keep the review at a manageable volume of full texts. Conference abstracts, book reviews and letters were excluded. The timeframe parameter of these searches was May to July 2016.

Section 2 explores the current debate on the assessment of clinical empathy. Section 3 presents the results from the structured literature reviews, and Section 4 deepens the discussion of the findings. The last section concludes the present study and identifies limitations and recommendations for future research.

2 Assessment of clinical empathy

2.1 Jefferson Scale of Empathy

Healthcare professionals' performance of clinical empathy can be assessed by using multiple choice questions, short answer questions and reports on patients' perceptions of their healthcare providers' attitudes.

The Jefferson Scale of Empathy (JSE) is a 20-item psychometric scale for measuring the empathy of physicians (JSPE version), medical students (S version), health professionals (HP version) and health-profession students (HPS version). The JSPE asks physicians to self-report on a seven-point scale. A higher score on the scale indicates greater empathy. Permission to use the scale has been given in 83 countries, and it has been translated into 53 languages and dialects, including Japanese (Jefferson Scale of Empathy 2016; Hojat et al. 2001).

Hojat et al. (2002) assessed physicians' empathy using the JSPE and found that female physicians' JSPE scores were significantly higher than male physicians' scores, and that psychiatrists had greater empathy than specialists in anaesthesiology, orthopaedic surgery, obstetrics, gynaecology or general surgery. There was little difference in the scores of physicians who are engaged in internal medicine, paediatrics, emergency medicine and family medicine. These results offer empirical evidence on empathy and help explain gender and professional differences in empathy.

The relationship between JSPE scores and patients' awareness was examined. Glaser et al. (2007) revealed that physicians' empathy and patients' assessments were significantly correlated, i.e. the more patients feel that their physicians are concerned about their feelings, the more likely patients are to assess that their physicians have considered their wishes when making treatment decisions. The results gave further validity to the JSPE and supported evidence that shows a relationship between self-reporting psychometric measurements by physicians and patients' perspectives.

2.2 Objective Structured Clinical Examinations

In undergraduate medical, dental and health science curricula, the Objective Structured Clinical Examination (OSCE) is used in countries worldwide to assess clinical competence in different healthcare professions. Japanese medical education officially introduced the OSCE in 2005. The examination consists of a series of 'stations', and at each station, students are asked clinical performance questions and given scores by examiners according to their knowledge, performance and communicative attitudes (Harden 2016). The OSCE employs a simulated patient (SP) who is trained to act as a patient at each station. The SP is required to provide the same experience to all students taking the OSCE, then to give feedback on their performance. The use of trained SPs allows students' performance to be evaluated under the same conditions (Harden 2016).

Hodges et al. (1996) examined the feasibility of developing medical students' communication skills and the reliability and generalisability of the OSCE. They found that performance of communication skills (e.g. rapport building, empathy, interview techniques and dealing with emotions) was linked to knowledge of the clinical encounters' content. Conversely, poor communication skills might hamper the gathering of content,

even when the student possesses adequate knowledge of the patient's problem. Brannick, Erol-Korkmaz, and Prewett (2011) pointed out that it can be more difficult to assess communication skills than clinical skills reliably when considering both skills as general traits. Although the OSCE is now standardised and used as an objective method of evaluation, reliably assessing students' communication skills is more complex, for example, due to differences between scenarios that create communication difficulties and easier or more difficult scenarios.

2.3 Failure to respond to patients' emotions

Although empirical studies and theoretical conceptualisations of empathy have emphasised the importance of empathy in clinical settings, doctors tend to be focused more on task-oriented communication, such as asking questions and providing information, and less on showing empathy, and they are likely to fail to respond to patients' emotions (Butalid, Bensing, and Verhaak 2014). Levinson and Pizzo (2011) found several reasons why doctors fail to respond to patients' emotions: 1) pressure: doctors are often under pressure since they need to deal with emotionally distressing situations within limited timeframes; thus, they often feel a need to quicken the pace of their interactions; 2) time constraints: even though mastering communication skills could improve their efficiency, listening to patients requires considerable time, which they often do not have; and 3) limited feedback: medical schools provide relatively limited education on effective communication skills, and medical students are rarely observed during their consultations with patients or given feedback to improve their communication skills.

Taking the time to communicate with each patient and respond in a facilitative manner is considered an essential clinical practice that ultimately results in better patient outcomes (Silverman, Kurtz, and Draper 2013). However, the circumstances that doctors must face on a daily basis also lead to compassion fatigue and emotional exhaustion. Gleichgerrcht and Decety (2013) developed a questionnaire that determines which aspects of clinical empathy are related to positive or negative outcomes, focusing on compassion, satisfaction and burnout among physicians. Physicians who experienced compassion fatigue – defined as having little or no satisfaction (or the pleasure derived from performing one's job well) – had the highest scores for personal stress as well as the strongest indicators for compassion fatigue. Washer (2009: 14) notes that "if you become too involved with your patients, there is a danger that you will become less able to provide what they need from you". It has been suggested that professionals need to maintain a level of professional distance between themselves and their patients, while demonstrating that they understand the patients' perspectives.

Some studies examined the decline of empathy among medical students and its association with burnout. Krasner et al. (2009) found that student burnout can occur early

in the medical educational process, and that students' emotional exhaustion can be linked to a decreased ability to express empathy. Neumann et al. (2011) undertook a systematic literature review on empathy decline in medical students and residents, and demonstrated that decreases in displays of empathy were explicitly present. Medical students need to develop their confidence and the ability to manage complex interactions. It can be said that clinical communication assessments through the OSCE and skills training using simulated patients (SPs) for the clinical examination would play a significant role in students' progress.

3 Results

3.1 Results for Question 1: Conceptualising empathy in the education context

3.1.1 Guidelines

In *The White Paper on Medical Education* in Japan, Moriya (2014) indicated that, although details regarding the number of classes for communication skills training in each medical school in Japan have not been publicised and remain uncertain to this day, the demand for communication skills training can be assumed to have expanded, with a particular emphasis on clinical clerkship (a style of clinical training wherein students are involved in medical care for patients as members of a medical care team in a hospital ward). In response to the official introduction of the OSCE, most of the medical schools in Japan have administered the test to students during the latter half of their fourth year of study. This has considerably affected students' preparation for medical interviews, communication and clinical skills (Moriya 2014). *The Core Curriculum in Medical Education 2010* was developed as a set of guidelines for use in conjunction with the OSCE; the learning and evaluation items in the instrument were formulated on the basis of Ministry of Education, Culture, Sports, Science and Technology (2010).

From examples of the checklist for medical interviews, as part of the assessment of the OSCE, empathic communication skills can be summarised as follows: 1) maintain eye contact with the patient, not only when asking questions but also when listening to the patient; 2) use plain language to support the patient's understanding; 3) take an appropriate posture when listening to the patient; 4) take an attentive listening stance by using open-ended questions throughout the consultation; 5) use fillers and nods to facilitate communication with the patient; 6) use an appropriate listening style, for example, avoid interrupting the patient; and 7) use appropriate verbal techniques (e.g. volume and tone of voice and paraphrasing, repeating, summarising and/or conforming the patient's statements); and 8) express empathy towards the patient's feelings and circumstances verbally

and non-verbally, i.e. verbal expressions are not enough (Common Achievement Tests Organization 2016: 77). It was noticeable that most of these communication items focus on doctors' listening styles during consultations and describe non-verbal expressions of empathic attitudes. Another checklist for medical interviews mostly comprises information gathering on medical history, as well as emotional and social information (Common Achievement Tests Organization 2016).

The administration has also affected competence requirements in medical education at the time of graduation. Some medical schools have presented their own competence requirements on their websites as learning outcomes that focus on the education process (Takagi 2014). *The 2016 Educational Guidelines for the School of Medicine at Tokyo Medical and Dental University* provide examples of the communicative competence with patients and their families, as well as the recognition of the importance of empathy that students require upon graduation. The examples are listed as follows (original Japanese text is shown in Footnote 1):

> Professionalism: Interpersonal relationship as a specialist[1]
>
> - Capable of contacting patients and their families with empathy, respect and consideration;
> - Capable of showing respect, empathy, responsibility, credibility and faithfulness in interaction with other specialists in medical care settings; and
> - Capable of taking actions required for building rapport between patients and their families during medical care.
>
> Communication: Communication with patients and their families
>
> - Capable of communicating with patients and their families while keeping a stance to support patients/their families faithfully; and
> - Capable of participating in a discussion with patients and their families as a member of a medical care team regarding serious, sensitive and difficult

[1]プロフェッショナリズム：専門職としての対人関係

- 患者および家族と、共感、敬意、思いやりをもって接することができる
- 医療における他の専門職との交流に際して、尊敬、共感、責任能力、信頼性、誠実さを示すことができる
- 診療において、患者や患者家族とのラポール構築のために必要な行動をとることができる

コミュニケーション：患者および家族とのコミュニケーション

- 患者や患者家族と、誠実で、常に患者 / 患者家族をサポートする姿勢を保ちながら、コミュニケーションをとることができる
- 重大で繊細な難しいトピック（sexual history、疾患名告知、退院計画議論、ターミナルケアなど）についての患者や患者家族との議論に、診療チームの一員として参加する

(Tokyo Medical and Dental University 2016: 197-200)

topics (sexual history, notification of disease name, discharge schedule discussion, terminal care, etc.)

These competencies, set as philosophical goals for graduates, contain skills for empathic interactions that emphasise rapport building and displaying respectful and supportive attitudes while also placing the importance of remaining scientific stances to maximise their professional roles. Although these are only some of the examples in the requirement, a significant number of interaction goals are listed in the guidelines published online (Tokyo Medical and Dental University 2016).

3.1.2 Educational textbooks

Five textbooks that were widely used in the syllabi of Japanese medical schools were reviewed. These materials were written by Japanese authors and were used for medical interview and clinical skills training. Table 1 categorises the primary objective of the material and definitions of empathy in clinical consultations.

Three materials in Table 1 primarily feature the OSCE (Furutani and Tanabe 2007; Suzuki and Abe 2011; Common Achievement Tests Organization 2016), and the other two illustrate case scenarios and communication techniques in medical interviews (Saito 2000; Iijima 2006). More specifically, Saito (2000: 52) suggests two aspects: 1) 'empathic expressions by listening' using nods, fillers, repeating and clarification; and 2) 'skills for support and empathy'. Here, Saito provides five skills and examples adapted from *The Medical Interview* proposed by Cohen-Cole (1994): *reflection* (e.g. 'You seem to be frustrated'), *legitimation* (e.g. 'It is a painful situation, as anyone can see'), *support* (e.g. 'I would like to do as much as I can'), *partnership* (e.g. 'Let's think about this problem together') and *respect* (e.g. 'While in a painful situation, you have been working hard'). Saito also notes that although 'support' is an approach to make the patient feel better, it is not always 'empathic'. Supportive comments might impede the doctor from listening to the patient and make the patient feel a lack of empathy (Saito 2000: 55). In sum, verbally expressed empathy in this context can be displayed by fillers, clarification and reflection, which mostly show an engagement (e.g. 'I am listening to you'), and this can be attentive, but indirect.

The five sets of materials in Table 1 provide conceptual definitions of clinical empathy. Although the explanations are brief, the term 'empathic attitudes' is frequently mentioned. Cognitive aspects as reflective of 'understanding' and 'acknowledgement' are coherent in these descriptions, as well as 'sharing emotions' such as anger and sadness (Common Achievement Tests Organization 2016; Furutani and Tanabe 2007; Suzuki and Abe 2011). It can be fair to say that most of these definitions are much closer to the ambiguity between empathy and sympathy. Furthermore, the explanations are simplified regarding verbally

Author(s)	Primary objective	Definitions of clinical empathy
Iijima (2006)	To deepen understanding of what is 'good communication' in clinical interactions for young doctors	N/A
Furutani and Tanabe (2007)	To acquire the basis of clinical skills techniques, which is required for students who take the OSCE	"Having an empathic attitude means trying to share patients' emotions and understanding their circumstances, which enable patients to relieve stress and worry" (p. 12)
Common Achievement Tests Organization (2016) [Institutional manual]	To provide comprehensive overviews of the OSCE and manuals for medical interview skills for OSCE candidates and examiners	"To show understanding through language or behaviour that signifies one understands patients' feelings and their circumstances; to properly make eye contact while listening to patients; to nod, give verbal acknowledgement and paraphrase; and to minimise interruptions" (p. 77)
Saito (2000)	To grasp the basis of one's ability regarding clinical communication and examples of expressions and attitudes	"Empathy occurs naturally when a doctor's feelings become unified with the patient's feelings, both suffering together when the patient suffers, and being pleased together when the patient is happy" (p. 55).
Suzuki and Abe (2011)	To develop a comprehensive understanding of medical interview skills performed in the OSCE and SPs	"Medical care staff often face strong emotions from patients, such as anger or sadness. Empathy in such cases is about understanding the sequence of events that stimulates these feelings in patients and by communicating with understanding" (p. 11)

Table 1: Summary of educational materials published in Japan

eliciting patients' statements, even though the educational guidelines place much emphasis on developing those skills for medical students.

3.2 Results for Question 2: Assessment of empathy in empirical studies

Six studies conducted empirical explorations of the assessment of clinical empathy for Japanese medical students, residents and clinicians. Among the six, two evaluated the empathy scores of medical students in different years, one used the Japanese version of the JSE-S (Kataoka et al. 2009; Abe et al. 2013), whereas the other used the Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF) together with the JSE-S to examine the differences between emotional intelligence and empathy in medical students (Abe et al. 2013). Aomatsu et al. (2013) conducted focus group discussions with medical students and residents to highlight the conceptual structure of empathy qualitatively. Two other studies measured empathy among clinicians, with one employing the Japanese version of the JSEP to examine differences through in-group comparisons of female physicians (Kataoka et al. 2012), and the other examining videotaped consultations between oncologists and SPs, using a behaviour rating scale to explore how each oncologist's characteristics influenced his or her empathic behaviour when delivering bad news (Kondo et al. 2013). The final study was a survey of patients in a primary medical care clinic, for which the Japanese version of the Consultation and Relational Empathy (CARE) measure was used (Aomatsu et al. 2014). Table 2 categorises the instruments used, sample sizes and study results.

Five studies in Table 2 are written in English, and one is in Japanese. The researchers used measurements developed in Western countries, such as the JSPE, and translated them into Japanese through back-translation procedures. These studies applied the original Western concepts and the definitions of empathy in their measurements, for example, Hojat and colleagues' (2007: 80) consideration of empathy as "a predominantly cognitive (rather than emotional) attribute that involves an understanding (rather than a feeling) of the patient's experiences, concerns and perspectives of the patient, combined with a capacity to communicate this understanding". Although these definitions reflect the Western concepts, the studies did not delve further into the concept of *kyōkan* (empathy) and the Japanese social context.

Aomatsu et al.'s (2013) study explored the conceptual structures of empathy between medical students and residents. While the medical students thought sharing patients' emotions was indispensable to displaying empathy, the residents believed, through clinical experience, that showing empathy depends on the patient's illness and anxiety factors (Aomatsu et al. 2013). This is clearly based on their clinical experience, as residents can cognitively decide what would be more appreciated in specific circumstances. These features seem more indicative of doctors' empathy as indirect expressions in response to patients' needs. As for declines in students' empathy, it has been reported that their

Study	Instrument used	Sample size	Results
Kataoka et al. (2009)	The Japanese version of the JSE-S	400 medical students in different years	Female empathy levels outscored males' levels, and empathy scores increased as students progressed through the course in the cross-sectional study However, the mean score for the Japanese sample was lower than those of U.S. and Mexican medical students
Kataoka et al. (2012)	The Japanese version of the JSPE	285 female physicians	Differences between people-oriented physicians and technology-oriented specialists were found; the former had significantly higher mean empathy scores than the latter
Kondo et al. (2013)	Videotaped consultations were analysed, and the behaviour rating scale was adopted to assess the quality and quantity of each empathic behaviour	60 oncologists and six trained SPs	Only age was related to empathy score; younger oncologists had higher scores than older oncologists
Aomatsu et al. (2013)	Two focus group discussions, in which participants were asked open-ended questions: The initial question was 'What do you think about the role of empathy in clinical practice?'	Six medical students and seven residents	Medical students and residents had different conceptual structures of empathy: Medical students thought that sharing emotions with patients was essential to showing empathy, whereas residents expressed empathy in accordance with their evaluation of patients' health status
Abe et al. (2013)	The Japanese versions of the TEIQue-SF and JSE-S	370 medical students in different years	The total TEIQue-SF scores tended to decrease as the students advanced. The total JSE-S scores significantly decreased in Year 4 but increased in Year 6. Male students had higher TEIQue-SF scores, and female students had higher JSE-S scores. No differences were found among school years. The scores on the TEIQue-SF and the JSE-S were weakly correlated
Aomatsu et al. (2014)	The Japanese version of CARE	317 patients in a primary medical care clinic	The findings supported the validity and reliability of the Japanese CARE measure in a primary care setting. Positive correlations with patients' overall satisfaction were found

Table 2: Summary of the assessment of clinical empathy in the Japanese context

scores significantly decreased in their fourth year, but increased in the sixth year (Abe et al. 2013). However, Aomatsu et al. (2013) noted that students' empathy does not simply decline, but rather changes qualitatively in clinical practice, as they develop skills in a professional role.

4 Discussion

The reviews of the extant literature reveal that empathy is referred to widely in policy documents and educational guidelines. This includes extensive references in the educational materials to how clinicians are expected to act in response to their patients' emotions during medical consultations. Elements of empathic communication are also evaluated or assumed to be an object of assessment in the OSCE in Japan. Therefore, infrequent displays of empathy noticed in past studies cannot be explained in terms of any lack of recognition of the value of empathy. However, research is lacking in regard to characteristics of Japanese doctors' empathy in the context of cultural expectations. It also remains unclear how relationship-building and gathering information to effectively account for patients' beliefs and anxieties might be achieved in practice in the Japanese context. Clinical empathy as a concept and use of the term remain reflective of the Western conception, and this deficiency might be related to uncertainty behind the term's conceptualisation and, particularly, to its application in the Japanese medical context.

The OSCE evaluation guidelines clearly require students to engage in empathic attitudes, which are then observed and assessed. Although the existing consultation skills training is limited to a fixed period during the students' fourth year of study before the initiation of clinical practice training, the training design, in collaboration with SPs, is considered to have a significantly beneficial effect on students' abilities (Noro, Abe, and Ban 2010), not only for science-based skills, but also for more humanistic clinical practice. In 2010, 43 out of 80 medical schools in Japan had trained their own SPs for their interview skills training (Shimura et al. 2011). Medical interview skills are complicated to acquire, a skillset that includes exhibiting empathy with consideration for patients' social and mental backgrounds, while conducting an expertise-based collection of data on patients' histories.

A more careful look at the textbooks reveals that explanations regarding empathic expressions mainly concern posture, gesture and the provision of clarifications, such as reflection and legitimation. These elements can be representative of a listening style. Such skills certainly create a supportive atmosphere and promote building rapport to achieve the goals of competence in medical students. However, there was a notable lack of encouragement to elicit patients' statements and observe their verbal and non-verbal cues. Secondly, Noro et al.'s (2010) study showed that SPs are more engaged in small talk with female medical students; time spent on small talk and time constraints per each patient

can be factors concerning contextual barriers that prevent male doctors from establishing a supportive environment. Analysis of potential contextual barriers, particularly attitudes and culturally based communication preferences, might shed further light on the discrepancy between education and practice.

As for cultural context, extant Japanese literature rarely reveals the nuances of 'sympathy' and 'empathy'. However, because of the difficulties in engaging in a sustained discussion in which each of these words denotes different ideas, an important requirement is to determine precisely how empathy differs from sympathy. Umeda (2014) explains that when engaging in an in-depth examination of the word 'empathy' in any language, one should correctly grasp the precise nuances of the original terms 'sympathy' and 'empathy' and their uses in specific contexts. Saito (2000) distinguishes the Japanese term 'empathy' from 'compassion' and 'support' in clinical settings: 'empathy' can be achieved through a listening style using nods or repeating and paraphrasing to clarify what a patient is saying, and 'compassion' and 'support' are more emotional desires to ease patients' sorrow and difficulties. The term 'empathy' varies greatly in the context of education. However, as a more advisable approach, the educational textbooks provide specific emphasis on eye contact, posture and displays of identification with patients' feelings through attentive behaviours. These features correspond to attitudes that show understanding of patients' predicaments.

Finally, although clear evidence of why Japanese doctors might not express empathy in consultations was not observed in the textbooks, empathic communication skills tied to listening styles were well described in the literature. A doctor's empathy, as indirect expressions responding to patients' needs in specific circumstances, can be further explored. In showing understanding, the doctor should pay special attention to whether the patient feels limited in telling stories. Social aspects, such as the time constraints per patient, are also inevitably factors that put doctors under great pressure. The importance of working with other professionals on a medical care team and participating in discussions with them were also described specifically in those educational guidelines.

5 Conclusions

The findings of this literature search have provided evidence that supports the promotion of clinical empathy in the Japanese medical education context. The evidence points to the following three outcomes: 1) clinical empathy as a concept in clinical communication remains reflective of Western conceptions, and uncertainty remains concerning the conceptualisation and definition in the Japanese context; 2) most explanations regarding attitudes/expressions, measured in response to patients' emotional needs, included descriptions of posture, gestures and an output of clarifications, such as reflections and

justifications, and these were representative of the listening style; and 3) in the textbooks, there was a notable lack of doctors' encouragement to elicit and address patients' disclosure of information. Although this study has investigated widely-used textbooks in Japanese institutions, further investigations of clinical empathy in Japan would be worthwhile. This might include research in collaboration with clinical practitioners. The operational background of medical schools varies as well, according to doctors' educational and cultural backgrounds. Theoretical education on clinical empathy and clinical communication is changing as healthcare systems evolve in many countries, including in Japan. It is also important to note that exploring empathy in different medical professions and healthcare institutions would elicit different insights in this area.

Further investigation on clinical empathy and its effectiveness will be required to conduct a well-designed study that widens the search parameters and includes several educational sources to explore how specific doctors' responses relate to effective communication. From a social and cultural perspective, such studies about communication in healthcare settings will also need to include patients' perspectives and expectations. Such further research will ultimately help medical students and professionals develop confidence and manage interactions with their patients and patients' families.

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