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Correlation between Patient-Centered Care and Clinical Empathy

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Abstract

Patient-Centered Care (PCC) and clinical empathy intertwine and share some premises. Studies on the correlations between clinical empathy and PCC still need to be available. This article aims to propose ways of approaching PCC and clinical empathy and contribute to the reflection on the correlation between both using their confluence axes to promote thinking about their relationship. The confluence axes proposed in this article are innovative and emerged from the specialized literature on the approaches. The confluence axes between clinical empathy and PCC are as follows: Empathetic Communication; Patient's Needs, Will, and Preferences; Relational Equanimity; Biopsychosocial Model and Therapeutic Alliance. In conclusion, this study underscores the urgent need for future research that scrutinizes the proposed thematic axes. This research is not just a call for further development in the field but a necessity as we strive to understand better and implement patient-centered care and clinical empathy in healthcare.

Keywords: *Healthcare; Patient-Centered Care; Empathy; Autonomy; Biopsychosocial.*

INTRODUCTION

The understanding of the patient's role has changed over time. In the second half of the 20th century, the fundamental reconstruction of the patient's identity beganduring political movements and emerging ideologies, which raised criticism of medical paternalism[1]. Following these steps, in the 21st century, a social, scientific, legal, health, cultural, and ethical movement called the "patient revolution" originated[2], an expression coined by Montori[3] and Richards[4]. This movement can be understood as a displacement of the patient as an object of care to the participant and protagonist of their care, putting the paternalistic model in check[5]. In the same sense, the movement is coupled with the emphasis on the relationship between professionals and patients in clinical practice, reflected in the approaches of Patient-Centered Care (PCC) and the recognition of the importance of clinical empathy. PCC and clinical empathy are approaches to the field of healthcare that intertwine and share some premises, such as (a) the assumption that care must be understood from the biopsychosocial model perspective, that is, psychological and social factors, not only biological, affect the health condition of the patient and their care; (b) the emotions of the professional and the patient integrate the relationship between both, as well as the decision-making process; (c) healthcare is relational, and the relationship between professionals and patients is a component that impacts health outcomes. Hence, Balint's statement stands out in the sense that it is not only the bottle of medicine or the box of pills that matters, but the way the physician gives them to the patient, that is, the entire atmosphere in which the drug is given and received by the patient.[6]

Based on these assumptions, this study assumes that understanding the correlations between PCC and clinical empathy contributes to providing quality healthcare[7,8], better health outcomes, increased patient and professional

1 PILNICK, Alison.Reconsidering Patient Centred Care. Bingley: Emerald, 2022.

2 ALBUQUERQUE, Aline; TANURE, Cintia. Healthcare bioethics: a new proposal of ethics for clinical practice. History and Philosophy of Medicine, v. 5, n. 2, 2023.

3 MONTORI, Victor. Why We Revolt: A patient revolution for careful and kind care, 2020.

4 Richards et al. Let the patient revolution begin. BMJ 2013;346: f2614.

5 HANSSON, Sven Ove; FRÖDING, Barbro. Ethical conflicts in patient-centred care. Clinical Ethics, v. 16, n. 2, 2021, p. 55-66.

6 BALINT, Michael. The Doctor, his Patient, and the Illness. New York: Churchill/Livingstone.

7 NOORDMAN, J. et al. Training residents in patient-centred communication and empathy: evaluation of patients, observers and residents. BMC Medical Education, v. 19, n. 128, 2019.

8 GRILO, Ana Monteiro et al. Attitudes toward Patient-Centred Care, Empathy, and Assertiveness among Students in Rehabilitation Areas: A Longitudinal Study. Healthcare, v. 11, n. 2803, 2023.

satisfaction, and treatment adherence[9]. It is emphasized that more than 75% of patients prefer an approach centered on their needs and will[10].

Studies on the correlations between clinical empathy and PCC still need to be available. Attention is drawn to Hardman and Howick's formulation of the relationship between Person-Centered Care and therapeutic empathy[11]. It is observed that the article above uses the referential of Person-Centered Care, which differs from PCC, as will be pointed out in this study. Although the expression "therapeutic empathy" is distinct from clinical empathy, its concept and dimensions are similar. Thus, it is noteworthy that the reflections emanating from this study led to the sense that there is a close relationship between person-centered care and therapeutic empathy, and it proposes that the training and qualification of health professionals encompass both constructs, as one enhances the other[12]. Similarly, Meraniuns et al. consolidate the idea that empathy is one of the elements of Person-Centered Care.[13]

Thus, this article proposes ways of bringing PCC and clinical empathy closer through the formulation of four Thematic Axes, contributing to the reflection on the correlation between both. The Thematic Axes between clinical empathy and PCC are as follows: Empathic Communication; Patient's Needs, Will, and Preferences; Relational Equanimity; Biopsychosocial Model and Therapeutic Alliance. These Axes are propositions from the specialized literature on the two approaches. Thus, it aims to contribute to providing theoretical and practical content to PCC, and, as for clinical empathy, its correlation with PCC provides its articulation with the other components of PCC, expanding its understanding in the context of healthcare. Moreover, considering that quality care must be patient-centered and empathetic, the relevance of thinking about the correlations between both is endorsed. The originality of the proposition is noteworthy, as studies on this correlation have not yet been explained in the literature on clinical empathy and PCC.

This theoretical article is based on the formulations proposed by Howick[14] and Halpern[15] on clinical empathy and Pilnick and Brickley and collaborators[16] on PCC. From the methodological perspective, this essay is based on the author's innovative proposition, not bibliographic research.

This article is structured in three parts: the first aims to address the concept of clinical empathy; the second deals with the theoretical boundary of PCC; and finally, it focuses on outlining the correlations between PCC and clinical empathy based on the Thematic Axes between clinical empathy and PCC as follows: Empathic Communication; Patient's Needs, Will, and Preferences; Relational Equanimity; Biopsychosocial Model and Therapeutic Alliance.

CONCEPT OF CLINICAL EMPATHY

Initially, it is essential to emphasize the gradual recognition of the importance of the relationship between health professionals and patients as a critical component of clinical care and a central construct of health systems. This human relationship, fundamental to health outcomes, also impacts patient engagement and adherence and their involvement in Shared Decision-Making.[17]Empathy deserves a place of prominence as an integral part of appreciating this nodal human relationship of healthcare. Empathy in healthcare has been the subject of studies over the last few years, specifically about empathy toward the patient. Howick et al. draw attention to the significant increase in studies on the subject in the previous 20 years. Several randomized studies show the improvement of patient outcomes due to

9 BRICKLEY, Bryce et al. A new model of patient-centred care for general practitioners: results of an integrated review. Family Practice, v. 37, n. 2, 2020, p. 154-172. ALBUQUERQUE, Aline. Empathy in Health Care: Communication and Ethics in clinical practice. Rio de Janeiro: Manole, 2023

10 NOORDMAN, J. et al. Training residents in patient-centred communication and empathy: evaluation of patients, observers and residents. BMC Medical Education, v. 19, n. 128, 2019.

11 HARDMAN, Doug; HOWICK, Jeremy. The friendly relationship between therapeutic empathy and person-centered care. European Journal for Person Centered Healthcare, v. 7, n. 2, 2019.

12 HARDMAN, Doug; HOWICK, Jeremy. The friendly relationship between therapeutic empathy and person-centered care. European Journal for Person Centered Healthcare, v. 7, n. 2, 2019.

13 MERANIUS, Martina Summer et al. Paradoxes of person-centred care: A discussion paper. Nursing Open, v. 7, 2020, p. 1321–1329.

14 HOWICK, Jeremy; REES, S. Overthrowing barriers to empathy in healthcare: empathy in the age of the Internet. Journal of the Royal Society of Medicine, 2017. Howick et al. A price tag on clinical empathy? Factors influencing its cost-effectiveness. The Royal Society of Medicine, v. 113, n. 10, 2020, p.389-393.

15 HALPERN, Jodi. What is Clinical Empathy? J Gen Intern Med, v.18, n. 8, 2003. p. 670-4, 2003. MONTEMAYOR, Carlos; HALPERN, Jodi; FAIRWEATHER, Abrol. In principle obstacles for empathic AI: why we can't replace human empathy in healthcare. AI & Society, 2021.

16 BRICKLEY, Bryce et al. A new model of patient-centred care for general practitioners: results of an integrated review. Family Practice, v. 37, n. 2, 2020, p. 154-172.

17 WANG, Yanjiao et al. The Effects of Physicians' Communication and Empathy Ability on Physician-Patient Relationship from Physicians' and Patients' Perspectives. Journal of Clinical Psychology in Medical Settings, 2022.

an empathic relationship in healthcare[18]. This empathy, in the capacity of nursing professionals, physicians, and other health professionals[19], is called clinical empathy.[20]

Educators and professional societies have gradually recognized the importance of empathy in care in the health sector worldwide. There is a consensus that the health professional's ability to establish an empathic understanding of the patient's situation is essential for developing the clinical relationship[21]. Health professionals refer to clinical empathy as a skill and good attitude that professionals need to have. As for training, medical courses have dedicated curricular time to developing empathy and compassion as professional skills.[22] In addition, in the UK, the Mid Staffordshire NHS Foundation Trust Report entitled *Dying Without Dignity*, prepared by the Health Ombudsman Service on end-of-life care, and the Leadership Alliance for the Care of Dying People Report shed light on the deficit of empathy in healthcare[23]. Clinical empathy is considered a fundamental determinant of healthcare quality, contributing to improving health outcomes.[24]

In one of the precursor studies on the theme, Mercer and Reynolds point out that empathy is a central aspect of consultations in general and, particularly, in the primary care environment. Thus, in primary healthcare, empathy emerges as a central component when patients' quality of care is addressed.[25] Specifically, in psychotherapy, Heinz Kohut and Carl Rogers are prominent theorists regarding the role of empathy in the therapeutic relationship[26]. It should be noted that this approach, particularly in psychotherapy, will not be the object of this paper. This does not mean the correlations made in later chapters on clinical empathy, Healthcare Bioethics, and patients' rights do not apply to psychotherapy.

The formulations of Howick[27] and Halpern[28] were chosen to define the concept of clinical empathy adopted in this book since both adopt multidimensional concepts of clinical empathy, which include its emotional component. However, before explaining the concepts of clinical empathy formulated by the cited authors, it should be noted that Mercer and Reynolds proposed the definition of clinical empathy as a form of professional interaction encompassing skills and competencies.[29] Moreover, this statement by Coulehan et al. is widely used in clinical empathy: "It is the ability to understand the patient's situation, perspectives and feelings, as well as to be able to communicate this understanding to the patient."[30]

Patients and health professionals commonly perceive the expression of the components of empathy differently. Likewise, their expectations of clinical encounters are different; that is, the professionals tend to take for granted their empathy in the interaction with the patient, and the latter brings that technical excellence is present in the professional conduct.[31]

Howick and Rees structure the concept of clinical empathy based on three components: (a) understanding the patient's situation, feelings, and perspectives; recognizing the difficulties of putting oneself in the patient's shoes; (b) communicating this understanding, checking its accuracy; (c) acting according to this understanding to help the patient. To this end, studies on the subject indicate that health professionals must have the following behaviors as guides of empathic care: (a) allowing sufficient time to understand the patient's history, (b) talking about general issues, (c) offering

18 Howick et al. Therapeutic empathy: what it is an what it isn't. Journal of the Royal Society of Medicine, 2018.

19 Tan et al define clinical empathy as that verified in the clinical environment, not limited to the empathy of health professionals.Tan, Laurence et al. Defining clinical empathy: a grounded theory approach from the perspective of healthcare workers and patients in a multicultural setting. BMJ Open, v. 11, 2020.

20 MONTEMAYOR, Carlos; HALPERN, Jodi; FAIRWEATHER, Abrol. In principle obstacles for empathic AI: why we can't replace human empathy in healthcare. AI & Society, 2021.

21 Don. Empathy in general practice: its meaning for patients and doctors. British Journal of General Practice, 2018.

22 KERASIDOU, Angelik et al. The need for empathetic healthcare systems. Journal of Medical Ethics, v. 47, n. e27, 2021.

23 JEFFREY, David. Clarifying empathy: the first step to more humane clinical care. British Journal of General Practice, v. 66, n. 643, 2016, p. e143-e145.

24 SILVERMAN, Jonathan; KURTZ, Suzanne; DRAPER, Juliet. Skills for Communication with Patients. New York: CRC, 2013.

25 MERCER, Stewart W.; REYNOLDS, William J. Empathy, and quality of care. British Journal of General Practice, 2002, p. S9-S12.

26 McINTYRE, Shannon Lindsay; SAMSTAG, Lisa Wallner. An integrative review of Therapeutic Empathy. Psychotherapy Bulletin, 2020.

27 Howick et al. Therapeutic empathy: what it is an what it isn't. Journal of the Royal Society of Medicine, 2018.

28 HALPERN, Jodi. What is Clinical Empathy? J Gen Intern Med, v.18, n. 8, 2003. p. 670-4, 2003.

29 MERCER, Stewart W.; REYNOLDS, William J. Empathy and quality of care. British Journal of General Practice, 2002, p. S9-S12.

30 COULEHAN, JL et al. "Let me see if I have this right...": words that help build empathy. Ann Intern Med, v. 7, n. 135, 2001, p. 221-7.

31 LEE, Thomas H. An epidemic of empathy in healthcare. New York: McGraw Hill, 2016.

encouragement; (d) giving verbal signals that the patient is being understood (hmm, ahh, etc.); (e) being physically engaged (by adopting specific postures, gestures, eye contact, appropriate touch, and others); (f) being welcoming during the consultation, from the beginning until the end. [32]

Thus, there is a consensus in the specialized literature that clinical empathy consists of three components.[33] The professional's understanding depends on the social, physical, and mental needs of the patient, as well as on their perspective. Showing understanding implies the professional's ability to share what they have learned with the patient. A professional who understands what is happening to the patient but does not communicate it is seen as non-empathic. These moments of shared communication of understanding are called "potential empathic opportunities," in which the patient's communication about what the professional expresses is also essential to create a positive relational dynamic between them. Finally, the objective of the professional is to adopt a behavior that tends to help the patient.[34]The study by Tan et al. found that health professionals and participating patients believe that emotion, a fundamental component of clinical empathy expressed in the behavioral domain, would imply the health professional's verbal and non-verbal communication and Person-Centered Care[35]. In summary, clinical empathy is a multidimensional capacity with two dimensions: a cognitive one, in which the professional understands the patient's perspective, and an emotional one, in which the professional attains the patient's emotions.

In this study, it is understood that adopting a behavior that tends to help the patient should be comprehended as that which starts from the professional's guidelines and can reflect the professional's shared understanding with the patient[36]. Therefore, it can be stated that clinical empathy involves the professional's ability to understand the patient's point of view and their health situation, express this understanding, and participate in decision-making based on this shared understanding.[37]

Patient-Centered Care: Theoretical Demarcation

PCC has its historical roots in the 1960s, corresponding to the expression of an ethical position that opposed the domination of doctors. And oppression of patients. Michael Balint is commonly credited with the initial formulations of PCC in 1955 and 1956, which were developed as part of his practice with general practitioners in the United Kingdom. Balint's proposal is aligned with the biopsychosocial model as it supports the holistic view of the patient in its spectrum, not only medical or biological but also social and psychological. Thus, one must consider the "pathology of the person as a whole." Balint also sheds light on the therapeutic alliance between professionals and patients, emphasizing that they are intertwined in a peculiar and asymmetric relationship and are characterized as an alliance. Also, in the 1950s, the model of the physician who made decisions without explanations was questioned, and the patient's autonomy was valued to balance the relationship between both.[38]

The process started in the 1950s and remained in the 1970s, and the work of Byrne and Long in 1976 was fundamental for transforming the patient's role from passive to active. In the same sense, Stimson, in 1974, reformulated the notion of non-conformity of the patient to the absence of their agreement, which came to be understood as a failure of the professional's activity and not of the patient. This also emphasized the relationship between both and the equal importance of the patient's perspective. In line with these new views, in the 1980s, at the University of Western Ontario, Canada, Joseph Levenstein and collaborators developed Patient-Centered Medicine as a clinical method in which the physician's agenda and that of the patient could be complemented[39]. It is noted that Hansson and Fröding attributed the expression "patient-centered medicine" to Professor Millar of the University of Aberdeen.[40]

In 2001, the United States National Academy of Medicine (formerly called the Institute of Medicine) established that

32 HOWICK, Jeremy; REES, S. Overthrowing barriers to empathy in healthcare: empathy in the age of the Internet. Journal of the Royal Society of Medicine, 2017.

33 Howick et al. A price tag on clinical empathy? Factors influencing its cost-effectiveness. The Royal Society of Medicine, v. 113, n. 10, 2020, p.389-393.

34 HOJAT, Mohammadreza. Empathy in health professions education and patient care. London: Springer.

35 Tan, Laurence et al. Defining clinical empathy: a grounded theory approach from the perspective of healthcare workers and patients in a multicultural setting. BMJ Open, v. 11, 2020.

36 BOGIATZAKI, Vasiliki et al. Empathy and Burnout Healthcare Professionals in Public Hospitals in Greece. International Journal of Caring Sciences, v. 12, n. 2, 2019, p. 611.

37 et al. How empathic is your healthcare practitioner? A systematic review and meta-analysis. Medical education, v. 17, n. 136, 2017.

38 PILNICK, Alison. Reconsidering Patient Centred Care. Bingley: Emerald, 2022.

39 PILNICK, Alison. Reconsidering Patient Centred Care. Bingley: Emerald, 2022.

40 HANSSON, Sven Ove; FRÖDING, Barbro. Ethical conflicts in patient-centred care. Clinical Ethics, v. 16, n. 2, 2021, p. 55-66.

PCC aims to improve healthcare in the 21st century[41]. The Institute of Medicine of the United States disseminated the lexicon of patient centrality in healthcare by placing it as one of the axes of high-quality care in the Report "*Crossing the Quality Chasm.*" Indeed, in the Report, the Institute calls for a fundamental healthcare reform to ensure that all Americans receive safe, effective, patient-centered, timely, efficient, and equitable care. The Report defines PCC as "care that respects and responds to the preferences, needs, and individual values of the patient and ensures that the patient's values guide all clinical decisions."[42]

As seen, the 21st century portrays patient protagonism and can be identified as the "patient century," while the 20th century was the century of the physician and the medical industry.[43]

In a substantial study on the concept of PCC, Brickley and collaborators identified four themes that permeate it, namely: (a) understanding the patient as a whole; (b) finding common ground; (c) the experience of time; (d) search for positive results. Regarding the understanding of the patient as a whole, patients have greater adherence to the treatment plan when the professional recognizes their values, lifestyle, and medical history, and the professional behaving in the opposite decreases patient satisfaction and adherence to the plan. Establishing a common ground concerns constructing a partnership relationship between the professional and the patient based on trust, which is a central element of this relationship. The experience of time involves the perception of the duration of the consultation and the longitudinality of care. The duration of consultation contributes to PCC, and the longitudinal bond of care predicts patient satisfaction, professional performance, and reliability, which are fundamental factors for PCC. Regarding the search for positive results, PCC is related to a number of these results, such as greater patient satisfaction, understandable communication, trust in the professional, support for the exercise of autonomy, and partnership formation.[44]

Achini and collaborators draw attention to the fact that there are movements to give PCC a consumption-oriented contour, attributing to the approach a free market perspective based on the idea that supports the consumer's right to choose their services.[45] In this context, Pilnick critiques PCC in that when PCC is based on the patient's choices and resembles the consumer's choice; this transforms the PCC approach into a landmark of neoliberal thinking[46]. Although this issue is not the object of this study, it must be noted that this perspective does not fit the concept of PCC supported here.

Finally, it is observed that although the indiscriminate use of Person-Centered Care as a synonym of PCC is verified, these are two distinct approaches that are not likely to be used interchangeably in this study. Indeed, according to Pilnick, the terms have different origins - the term Person-Centered Care stems from the work of psychologist Carl Rogers and describes a particular approach to psychotherapy. This approach expresses that psychotherapy falls under the patient's subjectivity, who has specific access to their psyche. In the case of medicine, there is a level of epistemic asymmetry to the extent that despite the patient having experiential knowledge about their condition, their interpellation with the knowledge of the professional is of a different nature and quality compared with psychotherapy. Moreover, in the case of psychotherapy, there is no "sick" person with all the cognitive, emotional, and physical vulnerabilities[47] added to the patient. Another distinction focuses on goals, and the central aspect of PCC is to provide a functional life for the patient, while Person-Centered Care is the achievement of a meaningful life.[48] This article does not aim to deepen the debate around the similarities and differences between Person-Centered Care and PCC but only to show that the distinction between the approaches is supported and in line with what Pilnick advocates.

Correlation between Clinical Empathy and Patient-Centered Care

Although the similarities between clinical empathy and PCC can be perceived intuitively - because their constituent elements converge for similar purposes and both concepts

41 BRICKLEY, Bryce et al. Putting patients first: development of a patient advocate and general practitioner-informed model of patient-centred care. BMC Health Services Research, v. 21, n. 261, 2021.

42 Institute of Medicine. Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academies Press, 2007.

43 PILNICK, Alison. Reconsidering Patient Centred Care. Bingley: Emerald, 2022.

44 BRICKLEY, Bryce et al. Putting patients first: development of a patient advocate and general practitioner-informed model of patient-centred care. BMC Health Services Research, v. 21, n. 261, 2021.

45 ADIKARI, Achini et al. Empathic conversational agents for real-time monitoring and co-facilitation of patient-centered healthcare. Future Generation Computer Systems, v. 126, 2022, p. 318-329.

46 PILNICK, Alison. Reconsidering Patient Centred Care. Bingley: Emerald, 2022.

47 ALBUQUERQUE, Aline. Empathy in Health Care: Communication and Ethics in clinical practice. Rio de Janeiro: Manole, 2023.

48 PlLNICK, Alison. Reconsidering patient-centred care: Authority, expertise and abandonment. Health Expectations, v. 26, 2023, p. 1785–1788.

shed light on the importance of a human relationship that characterizes care - the systematization of the correlation between clinical empathy and PCC requires investigation and reflection. As pointed out, studies dealing with the similar aspects of both approaches still need to be made available. In this regard, this article focuses on the proposition of Thematic Axes that develop the correlation between clinical empathy and PCC to contribute to studies on the subject. These Thematic Axes are innovative and emerged from the specialized literature on these two approaches. The Thematic Axes between clinical empathy and PCC are as follows: Empathic Communication; Patient's Needs, Will, and Preferences; Relational Equanimity; Biopsychosocial Model and Therapeutic Alliance.

Regarding the Empathic Communication Axis, for care to be effectively centered on the patient, the professional must understand the patient's perspective, which implies verbal and non-verbal communication, directing their attention by asking questions and maintaining eye contact[49]. In this sense, it is essential to use the concept of empathic curiosity formulated by Halpern. The health professional's empathic curiosity motivates them to seek to understand the individual perspective of the patient, supported by effectively engaged communication. According to Halpern and Fraga, this curiosity implies asking patients open questions, such as "How are things at home?" and "How are you feeling about school?". These questions prompt patients to broaden the spectrum of their speech, going beyond issues related to their health condition. For example, adolescent patients talk to the pediatrician about their difficulties at school and making friends, two emotional challenges that affect their mental health.[50] Moreover, in this Axis, it is noteworthy that the professional's active listening, which is intertwined with their empathic capacity, conveys respect, care, concern, and commitment.[51] Therefore, Empathic Communication, which employs clinical empathy, is a fundamental component of PCC, encouraging the professional in clinical practice to focus on the patient's perspective and the context in which they live.

The second Axis concerns the "Patient's Needs, Will and Preferences" theme. PCC is an approach that moves away from the traditional professional or disease-focused model to integrate patients' perceptions, needs, and experiences[52]. PCC promotes respect for the patient's preferences and will, which implies a safe space to express them.[53] A study by Janerka, Leslie, and Gill pointed out that pain management, the importance of family, and the patient's desire for space are essential components of PCC.[54] Clinical empathy allows the professional to connect and understand the patient's needs, will, and preferences uniquely; that is, the knowledge generated by employing empathy does not equal any other form of comprehension of the other's world. In this sense, the epistemic[55] or epistemological function[56] of empathy stands out, which consists of understanding it as a capacity that allows us to imagine the perspective of the other and understand it. This knowledge generated by empathy assists in the deliberation process on how to act, considering the patient's mental state and how they perceive their condition. Hence, the epistemic function of clinical empathy is essential to PCC and can contribute to the health professional approaching the patient's experiential knowledge, a central element of their participation and engagement in healthcare, to the extent that it allows knowledge to be gathered about the needs, will and preferences of the patient[57]. Recent research evaluating Shared Decision-Making in clinical practice highlights the low levels of integration of patients' preferences when discussing treatment options. Information related to patients' preferences, potentially relevant to the decision-making process, is still scarce in clinical practice. Therefore, integrating clinical empathy into PCC increases the comprehension of the patient's needs, wills, and preferences and their appreciation in decision-making.

49 BRICKLEY, Bryce et al. Putting patients first: development of a patient advocate and general practitioner-informed model of patient-centred care. BMC Health Services Research, v. 21, n. 261, 2021.

50 HALPERN, Jodi; FRAGA, Juli. Empathic curiosity is a way for health-care professionals to manage stress. WASHINGTON POST Available at: https://johannashapiro.org/wp-content/uploads/2022/05/EMPATHIC-CURIOSITY.pdf. Accessed on: jun 20th. 2024

51 BRICKLEY, Bryce et al. Putting patients first: development of a patient advocate and general practitioner-informed model of patient-centred care. BMC Health Services Research, v. 21, n. 261, 2021

52 Fix, Gemmae M. et al. Patient-centred care is a way of doing things: How healthcare employees conceptualize patient-centred care. Health Expectations, v. 21, 2018, p. 300-307.

53 HAVANA, Tiina et al. Patient's experiences of Patient-centred care in hospital setting: A systemic review of qualitative studies. Scand J Caring Sci., v. 37, 2023, p. 1001-1015.

54 Janerka, Carrie; LESLIE, Gavin D.; GILL, Fenella J. Development of patient-centred care in acute hospital settings: A meta-narrative review. International Journal of Nursing Studies, v. 140, 2023, p.104465.

55 JEFFERSON, William. The Moral Significance of Empathy. Available at: https://philpapers.org/rec/JEFTMS. Accessed May 18, 2022.

56 UGAZIO, Giuseppe; MAJDANeds, Jasminka; LAMM, Claus. Are Empathy and Morality Linked? In: MAIBOM, Heidi L. Empathy and Morality. Oxford: Oxford Univ.

57 ELWYN, Glyn et al. A three-talk model for shared decision making: multistage consultation process. BMJ, v. 359, 2017.

The next Axis deals with Relational Equanimity, which means that both the health professional and patient see each other in the clinical interaction as human beings and individuals in their own right[58]. Thus, Relational Equanimity is based on clinical empathy, which generates a connection based on the understanding of the patient's mental state and the imagination of their condition, building a deep sense of understanding about what the patient is going through[59]. By recruiting their empathy, the professional recognizes that the patient is a person like them and honors their experience as unique[60]. PCC implies that the patient is not treated as an object of interventions, procedures, and other measures, even for the greater good or the health professional's obligation to "save" the patient. In other words, if care is patient-centered and not disease or professional-centered, the patient must be seen as a person to be respected for their individuality. To this end, it is necessary to be recognized as a human being, which requires the empathy of the professional[61]. It is thought that when the professional dehumanizes the patient and does not recognize their mental state, it is difficult to centralize care in the patient, as in the case of newborn patients, patients with severe dementia or intellectual disability. Thus, Relational Equanimity is a fundamental theme for PCC, as the patient will be perceived as a similar being whose internal world is valued, and it is also essential for clinical empathy, as its function of recognizing the patient's humanity is acknowledged.

The fourth Axis deals with the Biopsychosocial Model, according to which the health condition must be understood from the patient's point of view as a whole, specifically intertwined with their personal autonomy, perspective, and the search for the realization of their life purposes[62]. This concept of patient integrality is found in the initial studies of Engels, a formulator of the biopsychosocial model of health and disease[63]. According to this model, care implies incorporating various factors related to the patient's health condition, such as social and psychological[64]. When describing PCC, Mead, and Bower[65] include the biopsychosocial perspective, which is associated with the holistic paradigm, according to which the patient is perceived not only from their health condition but also from emotional and social factors[66]. Therefore, PCC is intertwined with the biopsychosocial model of health and disease, which includes considering the patient's individuality in addition to their clinical diagnosis and incorporating their needs, will, and preferences.[67] Thus, PCC emphasizes that each patient is unique and should be considered as such[68]. To this end, clinical empathy, which includes the professional's curiosity[69], expands the understanding of the patient's condition, encompassing emotional and social factors. Therefore, psychological and social factors are brought to the clinical encounter when the professional is curious and expresses a wish to know more about the patient, their family life, their work and circle of friendship. Halpern states that doctors need to cultivate their curiosity about their emotional reactions and how they can deal with the patient´s experience[70], which can help them not feel unskilled in bringing psychological and social factors to the care scenario. In addition, clinical empathy involves the professional considering the patient's perspective, not "putting oneself in the patient's shoes" but imagining the patient in the situation they find themselves in. This consideration of an "other-oriented" perspective consists of finding a "space between" my perspective and that of the other, going beyond the egocentric starting point[71]. Hence,

58 MAIBOM, Heidi L. What can we learn by taking another's perspective? In: MATRAVERS, Derek; WALDOW, Anik. Philosophical Perspectives on Empathy. London: Routledge, 2021, p. 74-89.

59 MAIBOM, Heidi L. What can we learn by taking another's perspective? In: MATRAVERS, Derek; WALDOW, Anik. Philosophical Perspectives on Empathy. London: Routledge, 2021, p.74-89.

60 MAIBOM, Heidi L. What can we learn by taking another's perspective? In: MATRAVERS, Derek; WALDOW, Anik. Philosophical Perspectives on Empathy. London: Routledge, 2021, p. 74-89.

61 HERRING, Jonathan. Law and the Relational Self. Cambridge: Cambridge Univ.

62 BOLTON, Derek; GILLET, Grant. The Biopsychosocial Model of Health and Disease. London: Palgrave, 2019.

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including psychological and social factors for the treatment, extrapolating the biomedical ones can be increased through clinical empathy, which provides the professional with an opening to the different dimensions of the patient's life.

The last axis concerns Therapeutic Alliance, which implies forming a partnership between health professionals and patients based on trust. This relationship impacts both the professional and patient; that is, the patient is affected by the professional, who in turn is affected by the patient, thus the Axis of Relational Equanimity. Also, Therapeutic Alliance is based on verbal and non-verbal communication, encompassing the professional's attention, eye contact, and empathy and connecting with the Empathic Communication Axis. It is emphasized that trust is a constitutive element of this Alliance and is engendered when the professional is open, honest, and aware of their limitations[72]. The construction of this relationship of partnership and trust is imbued with the time available for the consultation and should be enough to allow the patient to be listened to. Research has shown that patients feel supported when the professional gives them time and shows interest. Similarly, another study pointed out that patients have high confidence when the professional dedicates more time. Quick consultations negatively impact the professional's empathy, participation, and active listening, which is associated with the existence or absence of PCC.[73] Empathy is a human capacity whose primary function is forming and maintaining social bonds[74] – a predictor of prosocial behaviors, such as care actions towards the other[75]. Empathy deepens mutual knowledge and allows the construction of a relationship of trust, an indicator of a solid relationship. Thus, empathy promotes closeness, relationship satisfaction, and the motivation of prosocial behaviors[76]. Moreover, the Therapeutic Alliance that forms a partnership between the health professional and the patient is strengthened when clinical empathy is recruited, not only by reinforcing the element of trust but also because empathy signals to the patient that they and their world are essential and this directly affects the quality of care[77] and the effectiveness of PCC.

In short, PCC presupposes an openness to the other and a decentralization of the professional in favor of recognizing the patient's world and valuing them equitably, and this involves the professional's empathic capacity. It is known that such capacity implies the professional's emotional self-regulation and self-knowledge. Empathy is a human capacity that requires this differentiation between what is mine and another's, which presupposes a non-identification with the other person's mental state. To do so involves contact with one's own emotions and thoughts; therefore, the openness demanded by empathy is not only for the world of the other but also for the internal world so that the person can connect with the other without projecting or identifying themselves. Thus, clinical empathy is a demanding capacity, and for it to be carried out in the daily life of professional practice, it presupposes adequate training and constant exercise, as well as emphasis on the health professional's self-care. Hence, to be achieved, PCC and clinical empathy impose a commitment not only of the professional but also of the entire health system, its managers, and leaders to provide the necessary environment for these approaches to flourish.

FINAL CONSIDERATIONS

Although PCC is consolidated as the approach to be adopted by health systems to achieve better health outcomes, overcome paternalism, and achieve a desirable quality of care, its correlation with clinical empathy remains peripheral, with little in-depth research. This study sought to outline thematic axes that provide opportunities for reflection on how to approach PPC and clinical empathy, showing that both approaches converge for the patient's protagonism, combined with recognizing the importance of their relationship with the professional. Thus, PCC is not an approach that gives absolute priority to the patient's autonomy, leaving aside the fact that care is always relational and that, despite the needs, will, and preferences being the vectors of decision-making, it is necessary to take into account the presence of the professional and their shared humanity. In conclusion, this study points to the need for future research that scrutinizes the proposed thematic axes and contributes to the thinking of PCC coupled with clinical empathy, which brings elements to PCC application that are usually not considered, such as emotions, the relational nature of care

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and empathic communication. A new culture in healthcare emerges in our century, showing that technological advances and the focus on medication do not account for the human complexity expressed in the process of becoming ill and in the act of caring.

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