THE NURSE, EMPATHY, AND PATIENT SATISFACTION

by

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A dissertation submitted to the faculty of
the University of Utah
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

College of Nursing
University of Utah
August 1990
THE UNIVERSITY OF UTAH GRADUATE SCHOOL

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ABSTRACT

Nursing is both an art and a science. Empathy has been described as the "art of nursing" (Carper, 1978). The science of nursing is evident in modern health care settings. A balance of the art and science of nursing should be encouraged. Empathy is the ability to put oneself in another's place and appreciate an experience from the other's point of view. Clinical empathy is acting upon this gained insight to plan and provide patient care. While nurses agree that empathy is important to nursing, to date, researchers have not studied the relationship between nurse empathy and patient satisfaction using qualitative methods.

A case study approach was utilized to allow various methods of data collection and analysis. The study site was a magnet hospital using primary nursing since 1975. A purposive, nurse manager-nominated population of 17 primary nurses, and 12 nurse-nominated patients was obtained. Twelve nurse-patient pairs, and 12 key leaders were included in the study.

Data collected included 41 interview transcripts from nurses, patients, and key nursing/hospital leaders.
Nurses completed the Myself-toward-Other component of the Barrett-Lennard Relationship Inventory (BLRI) and the LaMonica Empathy Profile. Patients completed the Other-toward-Self component of the BLRI and a Patient Satisfaction Index. Both groups completed demographic questionnaires. Artifactual information was also subjected to content analysis.

Content analysis of interview transcripts and artifactual information was ongoing during data collection and analysis. Findings indicated that nurse empathy positively influences patient satisfaction with care. Nurses and patients agreed the relationship that developed between the nurse and patient was very important. Nurses expressed a love of nursing and a joy in helping others. Nurses believed their empathic approach to patient care accounted for their satisfaction with nursing. Patients identified the most important nursing actions as "being there," and "taking time to sit down and listen." Nurses identified an ability to establish and maintain appropriate levels of involvement in nurse-patient relationships as important for effective nursing care. Implications for nursing administration, education, and practice are to foster empathic awareness in nurses and facilitate appropriate relationship development between nurses and patients.
This dissertation is dedicated
to my best friend and husband,
Thaddeus Robert Fedoruk,
with my sincerest
thanks and love.
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ACKNOWLEDGMENTS

Many individuals were intimately involved in the development and completion of this dissertation, and I would like to take this opportunity to personally acknowledge and thank them for their insight, wisdom, and assistance. First, I would like to extend my sincere thanks and appreciation to the members of my supervisory committee. This study would not have been possible without the continued support and assistance of Dr. Sharon Sims, my Chairperson and now my friend, who helped me take my first swim through the veritable "sea of data" that were generated in this study. Dr. Imogene Rigdon's wonderful sense of humor and ability to put everything in perspective saved me from despair on several occasions. Dr. Joan Goe offered her thoughtful support and insight on the educational and administrative implications of the findings of this study. Dr. Neal Whitman's contributions from his vast knowledge of higher education literature, and his fresh perspective from outside the domain of nursing, were invaluable in expanding the scope of implications for this study. My empathy literature specialist, Dr. Phyllis Gaspar, was extremely helpful at focusing my efforts at the inception of this study and continued to
offer guidance and support. While they were not on my
committee, I would like to acknowledge and thank Drs.
Margaret Dimond and Patricia Nuttall for their assistance
during the proposal phase of the study.

I would like to extend my sincere appreciation to the
patients, nurses, and administrators of the study facili-
ty. They opened their minds and hearts to me during this
study and I will forever be enriched by their insights and
experiences. Their stories were filled with rich and
meaningful incidences and it was my task to accurately and
honestly represent their experiences and values. A number
of patients did not live to receive the final report of
this study; this dissertation is, in a sense, a memorial
to their insights and experiences.

I would like to thank my parents, Harold and Delores
Brown, whose belief in the merits of a good education was
instrumental in my continuing my education. I would also
like to thank my grandmother, Alma Sigman, who always
believed unconditionally in my abilities to do great
things. I regret that she did not live to see the comple-
tion of this study, but am confident that she has been
following my progress closely from "the other side."

Finally, I would like to acknowledge my classmates,
colleagues on the night shift, and friends who offered
their support, encouragement and a listening ear at those
times when it was most needed. Thanks to my classmates
Mary Ann Lambert, Mary Ann Johnson, Cathy Heriot, and Marty Rhea, and also to my friend, colleague and proof-reader Susanna Schultz. I think they are as happy to see me complete this study as I am.
CHAPTER I

PROBLEM STATEMENT AND
LITERATURE REVIEW

Statement of the Problem

Nursing is both an art and a science. Empathy is identified as a major component of the art of nursing. Empathic nursing care should be valued by both the profession and the recipients of nursing care, just as the scientific aspects of nursing are valued. It is reasonable to assume that nurses with higher levels of measured empathy would deliver more empathic nursing care than nurses with lower levels of measured empathy. Empathic nursing would mean the nurse would attempt to understand the patient's experience from the patient's perspective (empathize) and subsequently use this knowledge in planning and delivering nursing care. It is theorized that patients who receive empathic nursing care will be more satisfied with their nursing care as that care will have been more personalized. Patient satisfaction with nursing care is important to the individual nurse and to the nursing profession as a whole. As nurses become more accountable for quality of care delivered to patients (as opposed to formerly being accountable to the physician),
patient satisfaction with nursing care becomes an important indicator of the health, vitality, and public support of the nursing profession. At this time, there are no identifiable studies combining qualitative and quantitative methods that indicate patient satisfaction with nursing care is affected by or correlated with empathic nursing care.

**Purpose of the Study**

This study had two purposes. The first was to describe what both nurses and patients perceive to be a nurse's empathic behavior. The second was to determine if there is a relationship between nurse empathy level and patient expression of satisfaction with nursing care.

**Research Questions**

The following research questions were formulated for this investigation:

1. What is, and what conveys, empathy as exhibited by the nurse from patient and nurse perspectives? How do these two perspectives compare?

2. What influences patient satisfaction with nursing care from patient and nurse perspectives? How do these two perspectives compare?

3. What is the relationship between empathy as exhibited by the nurse, and patient satisfaction with nursing care from patient and nurse
perspectives? How do these two perspectives compare?

4. How does information obtained from key leader interviews and artifactual evidence compare to what patients and nurses say about empathic nurses and patient satisfaction?

5. Is there a relationship between quantitative data and qualitative data obtained about empathic nurses and patient satisfaction with nursing care?

Review of Literature

Empathy

The Art of Nursing

Nursing is both an art and a science. The scientific aspect of nursing has received much attention and discussion since the 1950s as a response to the increasingly technical nature of the health care field and increasing recognition of nursing as a profession. Nurses have found it very difficult to clearly articulate components or characteristics of the art of nursing. Florence Nightingale was the first person to identify nursing as both an art and a science (1860). Elaborating on this concept and recognizing the need for nursing science, she said, "Nursing the sick is an art, requiring an organized, practical, and scientific training" (1954, p. 320). Nightingale wrote,
Nursing is an art; and if it is to be made an art, it requires as exclusive a devotion, as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or cold marble, compared with having to do with the living body ...? It is one of the Fine Arts ... the finest of the Fine Arts. (1954, p. 355)

Wiedenbach (1964) offered her treatise that the art of nursing is "characterized by individualized action, one-to-one relationships," (p. 36) and that underlying the art was "a thinking-feeling process that was involved with analysis of information" (1964). Anthony and Carkhuff (1976) recognized that technology in health care was resulting in an alteration in the balance of art and science in health care and said,

The ever-increasing growth of health care technology demands a similar increase in the health care professional's ability to deal with the psychological concerns of the patient. For there is a real danger that the patient's emotional and psychological functioning will be increasingly ignored. (p. ii)

As Watson (1981b) eloquently stated, "Just as there is a scientific quest in nursing today, so there also must be an artistic quest" (p. 245). The practice of nursing is an art and a science, yet there has been little research on the artistic component of nursing and what effect it may have on patient care.

Empathy and the Art of Nursing

Carper (1978) identified four fundamental patterns of knowing in nursing. These four patterns included empirical knowledge, personal knowledge, ethical knowledge, and
esthetic knowledge. Carper further elaborated on the esthetic knowledge in nursing as containing one most important element: empathy. "Empathy--that is, the capacity for participating in or vicariously experiencing another's feelings--is an important mode in the esthetic pattern of knowing" (p. 17). The quality of interpersonal knowing and acting upon that knowledge is the art of nursing.

The scientific aspect of nursing is valued by nurses and hospital managers. A central question today should be, "Is the art of nursing as valued by nurses as the science of nursing?" As Forsyth (1980) stated in her conceptual analysis of empathy, "Does the organizational structure of nursing allow for this patient contact, or is the nurse busy with other than patient concerns" (p. 41)? Patient care is the "raison d'être" for nurses and the profession of nursing. Is there any evidence that patients value empathic nursing care? Perhaps the central question is, should nurses be concerned with delivering empathic nursing care because patients are more satisfied with empathic nursing care?

In this era of cost containment and limited financial resources for hospital revenues, hospitals are increasingly forced to compete for patient patronage and patient revenue. Hospitals are centers for patient care. Nurses are the largest percentage of caregivers in a hospital. If
patients did not need direct and ongoing nursing care, they would not be in the hospital, but could be treated in surgical outpatient centers or clinics. To enhance the public image of nursing, and to be true patient advocates, nurses should be concerned with whether or not a patient is satisfied with nursing care received while hospitalized.

Empathy

The word empathy is derived from the Greek, "empathia," which implies an active appreciation of another person's feeling experience (Goldstein & Michaels, 1985). Modern usage of the word "empathy" was developed from the German word "einfühlung," which literally means "feeling oneself into." Theodor Lipps (1903), a German philosopher, used the term "empathy" in an esthetics text to refer to the joyful, personal feeling when viewing an object of art. This feeling of esthetic empathy is commonly experienced as the teary-eyed reaction the viewer may have to a painting or sculpture, or an especially moving passage of music. Lipps asserted that this feeling came from the infusion of oneself into the object being viewed and in feeling a oneness with that object. Empathy may be viewed as an esthetic form of knowing.

Empathy is also a personal form of knowledge. Polanyi (1958) asserted there is a "personal participation" of the knower in all acts of understanding (p. vii). The concept
of personal knowledge, or the experience the individual has when knowing, is said to be both subjective and objective in nature. Knowing is subjective in that the individual is experiencing it, objective in that the individual must observe the item that he or she is striving to know. Polanyi alludes to the interpersonal dimension of communication without actually using the word "empathy."

Martin Buber (1937), in his philosophical work *I and Thou*, maintained that human experience may take two forms. The "I and It," referring to human interactions with objects, and the "I and Thou," referring to human interactions with humans or living things. Buber stated, "The man who experiences has no part in the world. For it is 'in him' and not between him and the world that the experience arises" (p. 5). In clarifying the concept of "I-Thou," Buber stated, "the primary word I-Thou establishes the world of relation" (p. 6). The I-Thou experience is described as an "eternal form of art," in that the experiencing of this relationship is esthetic in nature. Buber's concept of "I-Thou" was often used in early empathy literature.
Definition of Empathy and Related Concepts

For this study, empathy was defined as the taking of the role of the other, viewing the world as the other sees it, and vicariously experiencing the other's feelings (Goldstein & Michaels, 1985; Rogers, 1975; Zderad, 1969). Empathy implies being adept at reading the other's nonverbal communication and interpreting the other's underlying feelings. Finally, empathy is exuding a feeling of caring and sincerely trying to understand the other in a nonjudgmental and helping way (Goldstein & Michaels, 1985; Rogers, 1975; Zderad, 1969).

Several concepts are mistakenly used to refer to empathy. Clarifying and defining these concepts will serve to clarify the concept of empathy. One such term is "sympathy." Sympathy is described by Zderad as "empathy plus" (p. 658). Sympathy is characterized as feeling "with," rather than "through," the other. Sympathy connotes pity, condolence, and the acceptance of the other's values about the feelings being experienced. When one sympathizes, there is no therapeutic intent to the experience, as one becomes subjectively involved with the other and the experience (Goldstein & Michaels, 1985; Zderad, 1969).

Another concept related to empathy is "projection," which is the attribution of one's own attitude or perspective on the other. With projection, the distinctiveness between the individual and the other is lost. Projection
is an unconscious process and individuals may be unaware they are projecting their thoughts and feelings onto the other (Goldstein & Michaels, 1985; Zderad, 1969).

"Understand" is a word frequently used to convey that one person is cognizant of how another person sees, feels, or thinks. Understanding is different from empathizing in that understanding is more a purely intellectual activity without the vicarious experiential nature of empathy. One can understand another without empathizing with them.

Finally, "identification" is a term commonly and erroneously confused with "empathy." "Identification" is a mechanism whereby one individual endeavors to pattern himself after another. "Identification" can be thought of as a special instance of role-taking, which is more emotional in nature than empathy (Goldstein & Michaels, 1985; Zderad, 1969).

**Steps in the Empathic Process**

Specific and sequential steps have been identified in the process of empathizing. While some authors identify three steps (Zderad, 1969), others identify four or more (Goldstein & Michaels, 1985; Rogers, 1975). For this study, the researcher chose to limit empathy theory sources to those mentioned above (Goldstein & Michaels, 1985; Rogers, 1975; Zderad, 1969) as they are the ones most often cited in nursing empathy research and literature (Alverson, 1987; Brown & Hunter, 1987; Brunt, 1985;

Zderad (1969) identified three steps in the empathic process. Phase One is the "internalization" phase wherein the empathizer internalizes the other person. This is a form of identification that is temporary, as well as projection as the empathizer projects him or herself into the other. In this instance, the empathizer perceives the situation as if he or she were the other person. Zderad further postulated that this process is enhanced in long-term relationships and may account for intuitive knowledge of the other or flashes of insight into another's behavior.

Zderad's second phase, termed "inner response," is the phase of empathizing where the empathizer "tastes" the experience from the other's point of view. This phase is conceived of as being more unconscious than conscious in nature. There further exists a splitting of the ego in this stage, where one half observes and the other half experiences. Zderad identified this phase as a "vicarious" experiencing of the other's reality.

Zderad's final phase, "reobjectification," is the phase that distinguishes clinical empathy from natural empathy. It is the conscious withdrawal from the world of the other and the reentry into the empathizer's own world.
At this point in the empathizing process, the empathizer looks at the other's experience objectively and scrutinizes it critically. The empathizer uses past knowledge and theory to assist in understanding the other's experience.

Clinical empathy may be defined as empathy that is developed through practice and an "understanding of the process and factors that influence it" (Zderad, 1969, p. 659). Natural empathy is commonly experienced, as in feeling for or understanding the plight of accident victims or survivors, or other people we may read about in newspapers or view on the television news. Natural empathy does not necessarily lead to action based on empathic understanding.

Goldstein and Michaels (1985) combined a number of different theorists to arrive at four stages of empathic processing. Their first stage, "identification," precedes Zderad's first phase of internalization. In this phase of identification, the empathizer views the other person and becomes absorbed in contemplating the other's experiences.

Goldstein and Michaels' second stage, "incorporation," closely parallels Zderad's phase one, "internalization." In this stage, the empathizer takes the experience of the other person into him or herself. Goldstein and Michaels admitted this phase is difficult to distinguish from the first stage and offered the following clarification, "When
we identify, we project our being into others; when we incorporate, we introject the other person into ourselves" (Goldstein & Michaels, 1985, p. 2).

The third stage of empathizing is "reverberation." This stage is similar to Zderad's phase two of inner response. "Reverberation" is described as the echoing of the other's experience on some of our own experiences, which awakens a new appreciation for the other's experience. The key to this stage is allowing the other's experiences and the empathizer's experiences to be compared and contrasted at an affective level, through the use of fantasy.

Goldstein and Michaels' final stage of empathizing is the stage of "detachment." This stage is essentially identical to Zderad's third phase of reobjectification. It results in the deliberate removal of self from the other and objective analysis of the new insight into the other's experiencing.

Empathy, by its very nature, is a process that is best evaluated by individuals in the empathizing process—namely, the empathizer and the other person. The interpersonal, subjective, and affective nature of the empathic process in some ways defy observation from an objective third party (Carkhuff, 1969; Jacobs & Williams, 1983; Rogers, 1975; Truax & Carkhuff, 1967; Zderad, 1969). However, some theorists maintain that outwardly observable
measurable (Hardin & Halaris, 1983; LaMonica & Karshmer, 1978; Mansfield, 1973). Further discussion of the possible measurement of empathy is presented in an ensuing section.

To summarize, the empathic process is seen as both an affective and cognitive experience. The ability to practice and improve upon one's empathic skills, and the cognitive component of the empathic experience, differentiates clinical from natural empathy. Empathy also has elements that cannot be seen, but are experienced between the empathizer and the other.

Measurement of Empathy

As empathy is a critical component of nursing, it is theoretically important to determine the nurse's empathic ability and level of empathy. Because of the highly subjective nature of the phenomena of empathy and perceived empathy, measurement instruments that purport to measure "empathy" may actually be measuring some other unidentified attribute. However, a number of tools have been developed to assist those interested in empathy to determine empathy "levels."

One commonly used measurement of empathic abilities is the Empathy Subscale of the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1978). The BLRI contains two mirrored components of 16 questions that may be answered by either the nurse or the patient, the helper
or the helpee. These two components are the BLRI-OS (Other toward Self) and the BLRI-MO (Myself toward Others) and are used in assessing how one might expect others to see them, and how one might perceive others, respectively. The BLRI is of interest for this study due to its frequent use in nurse empathy studies.

Of particular interest for this study is LaMonica's (1986) Empathy Profile. Developed by a nurse for use in helping relationships, the LaMonica Empathy Profile (LEP) was developed from LaMonica's (1981) Empathy Construct Rating Scale. A more detailed discussion about both the LEP and the BLRI will be found in the instruments section in Chapter II.

Other researchers have developed tools to measure empathy levels (Barrett-Lennard, 1978; Conklin & Hunt, 1975; LaMonica, 1981) through self-assessment questionnaires (Barrett-Lennard, 1978), active listening assessment forms (Davis, 1983), role-taking tools, peer assessment tools (Truax, 1961), and observable indicators of the motions most commonly associated with empathic awareness (Hardin & Halaris, 1983; Truax, 1961). Authors of the tools indicate the instruments were developed primarily through expert opinion and reviews of lists of questions submitted by students and content experts. It is uncertain and unclear if any tool currently exists that was developed through qualitative interviews and/or content
oped through qualitative interviews and/or content analysis. Statistical reliability of various measures has been examined and these reliabilities have been correlated with one another (Conklin & Hunt, 1975; Gagan, 1983; LaMonica, 1981).

As Jacobs and Williams (1983) stated, "The issue, of course, is whether a concept such as empathic understanding can be explored fruitfully within (the) confines ... of operationism and empiricism" (p. 81). Jacobs and Williams' observation brings to light the underlying weakness of the premise "measuring" subjective and affective phenomena. Logical positivists maintain that if an item is identifiable or nameable, it must be measurable. This paradigm has served Western science well and has facilitated the development of the modern world as it is known today. However, recent developments indicate that by simply observing or measuring a phenomenon or object, we alter that which we set out to observe or measure. This discovery was made by nuclear physicists in their search for minute particles. Nuclear physics, a highly scientific, logically positivistic discipline, was dismayed to find that simply by setting up experiments with the intent of looking for subatomic particles, the particle, once found, was altered (Capra, 1975). This phenomenon of altering whatever was being studied simply through the act of studying it has sparked a debate that continues today
Looking at empathic awareness through the lens of logical positivism, can researchers, indeed, ever hope to measure that which may be beyond measure?

Doubt remains that any tool to "measure" empathy has adequate construct validity and actually measures what it purports to measure (Jacobs & Williams, 1983). Jacobs and Williams (1983) offered a few criticisms of measuring empathy. First, a scientific process, determining reliability of empathy measures, is trying to be applied to an unscientific concept, empathy. Second, other studies have shown that a rater's evaluation of the therapist's empathy level does not usually correlate with the patient's evaluation of the therapist's empathy level. Third, therapists are usually rated minimally empathic on standard empathy scales. Finally, empathy ratings are usually taken out of context, whereas empathic communication is contextual by nature.

In view of the issues raised by Jacobs and Williams (1983) and others (Avery & D'Angelli, 1973; Capra, 1975; Caracena & Vicory, 1969; Corcoran, 1981; LaMonica, 1979) about the applicability of a positivist's evaluations toward intersubjective, affective, and contextual phenomena, trying to measure empathy becomes a questionable pursuit. If measurement of empathy is not possible because of the issues raised above, what are empathy tools measuring? One thought, proposed by Eisenberg and Lennon (1983), is
that individuals respond to the tools in a way that they think they should respond to them. Eisenberg and Lennon observed and measured male and female responses to slides and movies designed to evoke an empathic response. They observed that while male and female study participants had similar physiological responses to these empathy-provoking images, the written responses on self-evaluative empathy tools indicated females were more empathic than males. Empathic abilities are thought to be more maternal and female in our culture, whereas males are expected to conceal their feelings. Eisenberg and Lennon's participants were responding to self-evaluative tests according to their upbringing and sex-stereotyped roles.

In summary, the premise of the use of any tool to measure empathy is suspect. The tool may not be measuring empathy, but some socially desirable attribute or expression of feeling. A tool is also unable to quantify an unquantifiable phenomena, such as a level of empathic awareness, or the empathic bond between two individuals. This is important information to consider when attempting to measure empathy in any situation.

Nursing and Empathy

Nurse theorists and researchers have been interested in the concept of empathy and nursing since the 1950s (Duff & Hollingshead, 1968; Kalisch, 1971a,b, 1973; Ludemann, 1968; Rohweder, 1969; Speroff, 1956; Triplett,
1969; Zderad, 1969). In more recent literature, there are repeated references to the importance of empathy, as well (Alverson, 1987; Brown & Hunter, 1987; Fenton, 1987; Johnston-Early, 1983; Knowles, 1983; LaMonica, 1979, 1981, 1986; Lind, Wilburn & Pate, 1986; Watson, 1985). Empathy may be the single most important factor in a therapeutic relationship. Nurses assert that therapeutic use of self is a component of an effective nurse-patient relationship (King, 1984; King & Gerwig, 1981; Travelbee, 1971; Watson, 1985; Wiedenbach, 1964). Empathy may be the most important factor in the therapeutic use of self.

Carl Rogers, a well-known psychologist, identified the four major components of a helping relationship in 1974. Rogers believed the most important component of a helping relationship was empathy (1975). Nurses, like psychologists, rely on their own interpersonal and nursing communication skills to help others. In essence, nurses rely on themselves as therapeutic agents to help others; the therapeutic use of self. The importance of empathy in therapeutic environments will be discussed in more detail in the section entitled "Helping Relationships."

Demographics of Nurses and Empathy

There seems to be a tacit belief that nursing education will instill in the student compassion and caring for others (King, 1984; King & Gerwig, 1981; Watson, 1985). Various studies administering empathy scales to
nursing students and nurses have indicated that the empathy levels of nurses are similar to those of the general population (Brown & Hunter, 1987; Brunt, 1985; Duff & Hollingshead, 1968; Forsyth, 1979; Kalisch, 1971a,b, 1973; LaMonica, Carew, Winder, Haase & Blanchard, 1976; LaMonica & Karshmer, 1978). The measured empathy level for the general population is considered to be below the minimally therapeutic range. Measurements of empathy below the minimally therapeutic range have been determined by some psychologists to actually be harmful to patient outcome (Truax & Carkhuff, 1967). Studies of practicing nurses indicate a few demographic variables that appear to correlate with empathy levels as measured by current empathy tools. The demographic factors thus far evaluated include level of education, age and nursing experience, parenthood, nursing specialty, and gender. Each factor will be discussed individually below.

Education. Two studies indicate baccalaureate prepared nurses have higher levels of empathy than associate degree nurses and associate degree nurses have higher levels of empathy than diploma nurses (Brunt, 1985; Forsyth, 1979). If measurements of empathy are to be the criteria of reference, it appears from these data that some element of nursing education serves to increase the nurse's empathic awareness.

Years in nursing and age. New graduates have higher
empathy levels than nurses who have been working for more than 2 years (Brunt, 1985; Forsyth, 1979). Older nurses are less empathic than younger nurses (Forsyth, 1979). However, head nurses were shown in one study to have higher empathy levels than staff nurses, regardless of their age or number of years working as a nurse (Forsyth, 1979). While no reason was given for higher levels of empathy among head nurses, one could suppose that the nature of a head nurse's duties, that remove him or her from intense contact with patients, could be a factor in this finding. This distance may allow head nurses to be more empathic because they are not directly and continually involved in patient care; thus, they may be able to more clearly ascertain what the patient may be thinking and feeling. Close, continual contact between the nurse and patient may result in a psychological "shell" forming around the nurse as a self-protective mechanism from frequent intense involvement with patients and the ensuing pain if they do poorly or die. Head nurses may not need this "shell" as they are not usually as intensely involved with patients.

Parenthood. Parenthood appears to influence nurse empathy also. Nurses who are parents are more empathic than nurses who are not (Forsyth, 1979). No explanation is offered for the correlation found between parenthood and increased empathy scores for nurses. Parenting and
nursing are both considered helping relationships. Perhaps a dual helping role serves to strengthen the individual's empathic ability in both roles.

Another reason for increased empathy levels in nurses who are parents may have to do with the use of imagination and fantasy. Stotland, Mathews, Sherman, Hansson, and Richardson (1978) asserted that an active imagination and the use of fantasy assist empathic development. One possible explanation for the increase in parental empathy levels is that parents may become reacquainted with the world of fantasy and imagination through the eyes of their children, and thus rediscover their ability to "imagine" what something might be like from another person's perspective.

**Nursing specialty.** Nurses vary in empathy levels by practice area. Forsyth (1979) found rehabilitation nurses the most empathic of the medical-surgical, psychiatric, and orthopedic nurses studied. Empathy scores of psychiatric nurses, traditionally viewed as needing high levels of empathy, indicated they were no more empathic than nurses on a medical-surgical nursing unit and orthopedic unit (Forsyth, 1979). One study designed specifically to ascertain if nurses working in intensive care units were less empathic than their colleagues in stepdown units failed to statistically support this hypothesis (Brunt, 1985). Brunt described the empathy levels of the entire
sample of nurses (N = 54) as "not high" (1985).

Gender. Measurement and comparison of empathy levels in males and females have yielded conflicting results (Eisenberg & Lennon, 1983; Forsyth, 1979). In one nursing study, the author noted anecdotally that the few male nurses who had participated in the study consistently measured higher in empathy levels than did the female nurses. No figures on this comparison were available as Forsyth did not have a large enough sample of male nurses (n = unknown) to statistically compare empathy scores to the total sample (N = 70) (Forsyth, 1979). Forsyth's measurements were obtained on a self-evaluative tool (Hogan, 1969) and the results are contradicted by the study by Eisenberg and Lennon (1983).

As has been mentioned above, Eisenberg and Lennon (1983) performed a detailed literature review and content analysis looking specifically for differences in male and female empathy ratings. Their results indicated that the deciding factor in the measured empathy level difference between sexes was the nature of the tool used to measure empathy. Females measured higher empathy levels than males when rating themselves on behaviors or affective responses. In contrast, few differences between the sexes in empathy measures were observed when physiological measurements of empathy were used (galvanic skin response, heart rate, blood pressure, etc.). The authors concluded
that physiologically, males and females respond similarly
to stimuli designed to produce empathic responses, but
will rate themselves in accordance with their sex's
stereotype on a self-evaluative instrument (Eisenberg &
Lennon, 1983). The findings of these two studies again
raise the question of validity of empathy measures; are
they truly measuring empathy, or some other attribute?

Patient's Perceptions of the
Empathy of Nurses

The patient's perception of a nurse's empathic
abilities is ultimately the most valid indicator of that
nurse's empathy level (Rogers, 1975). A high self-eval-
uation score on an empathy measuring tool does not neces-
sarily indicate the nurse's ability to convey empathy to
the patient. If the patient has not perceived empathy,
for all intents and purposes, empathy is not present.

Forsyth (1979) measured patient perceptions of nurses'
empathy levels by using the Empathy Subscale of the
Barrett-Lennard Relationship Inventory (1978). Results
indicated that 98% of the patients surveyed indicated they
saw their nurses as highly empathic, whether or not the
nurse measured high on the empathy scale. Forsyth
surveyed patients when they were still in the hospital and
patients were referred to the investigator by the nurses
the patients were asked to rate. While these design flaws
may account for the overwhelming positive results of the
study, additional evidence supports the finding that patients uniformly rate their nurses high on any empathy rating scale (Forsyth, 1979).

Gagan (1983) observed that the BLRI was constructed as a professional's self-test. As a patient population may be assumed to be more representative of the general population, use of the BLRI may not be the tool of choice for patient evaluation of nurse empathy. Gagan (1983) compared the BLRI with other measurements of empathy and determined that the BLRI might not be the best instrument for evaluation of empathy perceived by the hospitalized patient because the wording of the questions was more oriented toward client-therapist interaction and, thus, difficult to apply to the nurse-patient interaction. Gagan said, "an observatory, exploratory study is suggested to investigate and delineate the precise nature of the empathic process in the nurse-patient relationship" (Gagan, 1983, p. 71). However, the BLRI remains the only empathy rating scale that is designed for helper-helpee pairs and evaluates the empathic abilities of the helper from both individuals' perspectives.

Generally, investigators have done little to ascertain the patient's perceptions of nurses' empathic abilities. Rogers (1975) observed that the patient is a better judge of empathy than is the practitioner. Perhaps having nurses record their own empathy level is not the ideal method by
which to evaluate empathy levels of nurses.

**Related Concepts**

**Helping Relationships**

Since "empathy" was first used in esthetic and philosophical literature in the earlier parts of this century, other scholars and professions have discovered and used "empathy" in relation to their special area of interest. Psychology literature abounds with references to the topic of empathy, especially since Carl Rogers' 1958 article entitled "The Characteristics of a Helping Relationship" was published (Aspy, 1975; Barrett-Lennard, 1981; Batson & Coke, 1981; Berger, 1984; Carkhuff & Berenson, 1977; Carkhuff & Truax, 1966; Carkhuff, 1969; Clark, 1980; Davis, 1983; Eisenberg & Lennon, 1983; Goldstein & Michaels, 1985; Hackney, 1978; Jacobs & Williams, 1983; Margulies, 1984; Rogers, 1975; Rushton & Sorrentino, 1981; Smith, 1977).

Other disciplines that have used the concept of empathy in relation to their own theory and practice include education, educational psychology, counselor education, business management, theology, and medicine. It is interesting to note that many of the above professions also claim an element of "art" in their practice (i.e., the "art of teaching," or "the art of medicine"). The esthetic quality of these professions may interface at the concept of empathy and how this concept is individual-
the concept of empathy and how this concept is individually applied within each profession.

Helping relationships, according to Rogers (1958), are those in which "at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, (and) improved coping with life of the other" (p. 6). Education, educational psychology, psychology, theology, counseling, medicine, and nursing are considered to contain elements of a helping relationship.

Any helping relationship includes a contract entered into by the helper and helpee. This "contract" is not written, but is a social contract between a professional or person who is seen as "more-knowing" and the helpee (Carkhuff & Berenson, 1977). Carkhuff (1969) asserted that the helper must be cognizant of the "three Rs" of helping. These are,

... (1) the right of the helper to intervene in the life of another; (2) the responsibilities of the helper once he has intervened; and (3) the role the helper must assume in helping another individual and, concomitantly, the various role conflicts he encounters in attempting to implement the responsibilities implied by intervention. (p. xi)

Components of a helping relationship. Carkhuff and Berenson (1977) identified four major components that are consistent in helping relationships. These are empathy, positive regard, genuineness, and concreteness or specificity of expression. These four concepts as components

Rogers (1975) asserted that of the four ingredients of a helping relationship, the most important is empathy. Other theorists agreed with Rogers on this point (Batson & Coke, 1981; Carkhuff & Berenson, 1977; Clark, 1980; Forsyth, 1980; Gazda et al., 1982; Goldstein & Michaels, 1985; Margulies, 1984; Rushton & Sorrentino, 1981; Stotland et al., 1978). While the other three components of the helping relationship are important, studies have demonstrated and anecdotal notes from psychologists and psychiatrists have identified empathy as the factor that seems to have the most impact on patient outcome (Barrett-Lennard, 1962; Batson & Coke, 1981; Carkhuff & Berenson, 1977; Clark, 1980; Forsyth, 1980; Gazda et al., 1982;
Carl Rogers (1975) summarized the value of empathy in helping relationships in the following manner:

Very early in my work as a therapist I discovered that simply listening to my client, very attentively, was an important way of being helpful. So when I was in doubt as to what I should do, in some active way, I listened. It seemed surprising to me that such a passive kind of action could be so useful. (p. 2)

Over the years, however, the research evidence keeps piling up, and it points strongly to the conclusion that a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning. (p. 3)

The "Helper" Therapy Principle

An interesting consequence of being involved in a helping relationship is that the helper frequently benefits more from the interaction than the helpee (Reissman, 1965). Reissman called this phenomenon the "helper" therapy principle, using as examples Alcoholics Anonymous and other self-help groups. Reissman believed that often those people facilitating the group benefited as much, or more than, the people for whom the group was intended.

The "helper" therapy principle is of interest as a related concept to empathy because of the possibility that the nurse may actually benefit as much, or more than, the
ship with that patient. Committed nurses (Dickinson, 1975; Dimond, 1980; Vaillot, 1966) stated one of the factors that helped them maintain their commitment to nursing and to patient care was the benefit received from close and effective interaction with the patient. Perhaps a cycle begins in which empathic nurses reinforce their empathic development through their commitment to patients, resulting in a reinforcement of their commitment to patients, which again reinforces empathic development.

As mentioned above, some believe the helper in a helping relationship is meeting the helper's needs, not the helpee's need (Cialdini, Shaller, Houlihan, Arps & Fults, 1987). Batson and Coke (1981) conducted studies that lead them to assert that pure, or selfless altruism occurs under conditions where the helper experiences empathy for a helpee. Cialdini and colleagues asserted that when one helps another, the helper actually meets his or her own needs. Cialdini et al. (1981) investigated this issue using study designs and circumstances similar to those used by Batson and Coke. Cialdini and colleagues found evidence supporting their premise that the highly empathic helper actually acts upon an egoistic need to relieve the suffering or sadness of the other and not in a purely altruistic sense.

It is not the intent of this study to examine the motivations of nurses to apply empathetic awareness in
patient care situations. However, the "helper" therapy principle is an interesting concept that does relate to the underlying construct of nurse empathy.

Environment

The effect of the caring environment upon nurse empathy and patient satisfaction is mentioned here because it is thought that the environment may impact the establishment and development of nurse empathy and patient satisfaction. There are two identifiable components to the environment: the physical surroundings and the interpersonal surroundings. The first addresses the actual physical environment: color, the amount of sunshine, and the geography of the nursing unit or hospital. While the researcher believes the individual's physical environment is important, it is not the intent of this study to examine in detail the effect of the environment on nurse empathy and patient satisfaction. More attention will be given to the interpersonal environment in the nursing unit and hospital because the researcher believes from personal experience that this component of the environment has a definite impact on nurse empathy, and subsequently, on patient satisfaction.

The interpersonal environment within an organization has also been called a "corporate climate" or "organizational climate" (Tagiuri & Litwin, 1968). There has been an increasing interest in the concept of "climate" in
organizations, as reflected in both management and nursing literature (Alexander, 1988; Bragg, 1982; Duxbury, Armstrong, Drew & Henly, 1984; Gray-Toft & Anderson, 1985; Hart & Moore, 1989; Keenan & Newton, 1984; Lancaster, 1985; Lyon & Ivancevich, 1974; Magill, 1982; Scanlan, 1981). There is also interest in the motivation of others and how nurse leaders may improve climate and motivation of others (Johnson, 1982; Sossong, 1982; Sovie, 1987).

Briefly, the above authors and others assert that for nurses or workers in any organization to perform at their optimal level, the individual's perceived amount of control over the work environment has a positive effect on their motivation and satisfaction with the position (Tannenbaum, Wechsler & Massanik, 1961; Tannenbaum, 1962). Nurse authors also state that for nurses to be able to care and nurture patients, they in turn must be cared for and nurtured by their administrators. An environment must exist where the nurse feels safe and risk-taking and creativity are condoned and encouraged.

Theories of motivation and satisfaction presented by both Maslow (1954) and Herzberg (1966) were used by the above authors as a basis for their observations and studies of climate. Maslow's hierarchy of needs and Herzberg's motivation theory offered insight into how organizations can influence worker behavior. Briefly, Maslow maintained certain physiological and psychological needs
must be met before the individual can begin to achieve their highest potential, that of self-actualization (1954). Herzberg (1966) asserted that certain factors in the work environment become satisfiers or dissatisfiers and a balance of these factors directly affects how individuals perform and feel about their personal contribution to the organization, as well as their own personal worth. An environment supportive of individual growth, while meeting basic human needs is necessary to set the stage for caregiving.

An organization's "climate" has been repeatedly demonstrated to directly affect the attitude, motivation, and productivity of the worker within that organization (Alexander, 1988; Bragg, 1982; Duxbury et al., 1984; Gray-Toft & Anderson, 1985; Hart & Moore, 1989; Johnson, 1982; Keenan & Newton, 1984; Lancaster, 1985; Lyon & Ivancevich, 1974; Magill, 1982; Scanlan, 1981; Sossong, 1982; Sovie, 1987; Tannenbaum et al., 1961; Tannenbaum, 1962). Organizational climate is considered an important underlying construct in the study of nurse empathy and patient satisfaction, as the nurse must be comfortable within the environment in order to apply nurse empathy. Theoretically, the nurse would not be comfortable using nurse empathy in an environment where the nurse was not supported and could not meet his or her own basic needs.
Primary Nursing

Primary nursing as a mode of patient care delivery is important to mention as a related subject in this study for two reasons. First, because there is a unique, helping relationship that develops between nurses and their primary patients. Second, the researcher chose a primary nursing model of care delivery as a criterion for inclusion in the case study.

The development of a relationship between nurses and patients, like any relationship, is obviously more likely to develop if the people involved in the relationship interact regularly and have an interest in getting to know each other. Operating under this assumption, one may logically infer that the nurse-patient relationship would more readily develop in a primary nursing delivery system where the same nurse and patient interact on a daily basis and the nurse is invested in knowing and helping the patient meet identified needs.

The nature of the nurse-patient relationship is essentially a helping relationship. Characteristics of a helping relationship have been discussed earlier in this manuscript. The nurse-patient relationship is unique in that the patient has specific physical and psychological care needs related to hospitalization. Nurses' roles and education assist them in their efforts to meet those identified patient needs until such a time that the
patient can take over these actions or dies (Henderson & Nite, 1978). A critical component of this relationship is based on the ability of the nurse to assess, plan, and implement nursing care. Another important component is the patient's ability to communicate to the nurse his or her identified individual needs. These patient needs may be physical, psychological, or spiritual. No other health care provider in modern health care is in a position to assist the patient in meeting such a varying array of needs.

In days gone by, the activities of a general practitioner, the old "country doctor," who had known the patient and their family for years, would perhaps compare to those activities and interventions routinely performed by today's nurses. As George Will, a well-known journalist, social commentator, and layperson, noted in a Newsweek (1988) editorial entitled "The Dignity of Nursing,"

The American ideal of a doctor -- kindly, caring, reassuring Dr. Welby -- was essentially a nurse.... Nurses control the environment of healing.... A nurse ... superintends complex technologies, dispenses information and health education and strives for a holistic understanding of patients' needs, which include empathy. (p. 80)

In the first half of the 20th century, care of the sick was moved from the home to the hospital. Prior to the institutionalization of health care, professional nurses often contracted with individual families to care
for a family member during episodes of protracted illness, childbirth, or terminal disease (Donahue, 1985). The nurse, practicing nursing in this home environment and surrounded by the patient's family, intimately knew the patient's needs and world. He or she was essentially practicing primary nursing.

When health care became institutionalized, both the recipients and deliverers of health care felt there was an increasing emphasis on technology and rules, and a decreasing emphasis on the patient as an individual (Hegyvary, 1982). Patients did not appreciate the lack of personal attention to their individual needs that accompanied an efficient, technical, team-leading approach to patient care. Patient and nurse concerns sparked a movement to humanize the health care environment.

The concept of modern primary nursing was refined in the 1960s and 1970s as part of this increasing emphasis and interest in humanism and personalization of patient care (Hegyvary, 1982). Primary nursing is the mode of care delivery where one nurse assumes continuing 24-hour responsibility for coordination of a single patient's care. It is theorized that as primary nursing purports to develop a better nurse-patient relationship than other in-hospital modes of care delivery (such as team or functional nursing), primary nurses would be better able to manifest empathy with their primary patients. Many researchers
support the concept that primary nursing facilitates the nurse-patient relationship (Burke, 1982; Ciske, 1974a; Fairbanks, 1981; Hegyvary, 1982; Laszewski, 1981; Manthey, 1988; Marram, Barret & Bevis, 1979; Mauksh, 1981; McCarthy & Schifalacqua, 1978; Watson, 1975). Mauksh stated,

To ... maximize health potential, the relationship between the nurse and the client is critical. There must be a sense of concern and caring from the nurse, who brings to the relationship qualities of attendance, of service, and of participation in a mutually shared experience. (1981, p. 115).

Soon after the implementation of primary nursing, a flood of studies were conducted to ascertain if patients were more satisfied with their nursing care under a primary care system (Burke, 1982; Ciske, 1974b; Collins, 1975; Fairbanks, 1981; Hegyvary, 1982; Marram et al., 1979; McCarthy & Schifalacqua, 1978; Watson, 1975). As Hegyvary observed in 1982, reports of consumer satisfaction with primary care were based on questionnaires administered to patients, or from subjective, nonsystematic reports from patients. While some studies had inconclusive results regarding patient satisfaction with primary nursing, a number of studies did substantiate that patients felt the nurse was more responsive to their needs under the primary nursing system (Burke, 1982; Collins, 1975; Daeffler, 1975; McCarthy & Schifalacqua, 1978; Watson, 1975).
Patient Satisfaction

Donabedian pointed out, "... clients, providers, administrators, planners and economists may differ significantly in their views of quality" (1962, pp. 9-10). Some recent studies examining patient satisfaction with nursing care or the hospital experience have appeared in the literature (Burke, 1982; Davis-Martin, 1986; Donabedian, 1969; Forsyth, 1979; Gagan, 1983; Hegevary, 1982; Hinshaw & Atwood, 1983; Holt-Ashley, 1985; Kirchhoff, 1976; Risser, 1975; Watson, 1975; Wren, Longest, Keith & Walker, 1971). Most patient satisfaction literature evaluates patients' opinions of primary nursing, nurse midwifery, psychiatric nurse, and general nurse practitioner performance. A few researchers have looked specifically at patient satisfaction related to a change in nursing care delivery systems, usually from team to primary nursing (Burke, 1982; Hegevary, 1982; Watson, 1975). While not all studies were statistically significant, patients did report they were more satisfied with the primary nursing mode of delivery because of the continuity and rapport developed.

In an unpublished doctoral dissertation, Holt-Ashley (1985) investigated the relationship between nurse empathy and patient satisfaction through quantitative methods. Using a classic experimental design, two randomly chosen medical-surgical units and their respective nurses and
patients were included in the study. Pretests of empathy levels and patient satisfaction were obtained. Holt-Ashley then implemented 7 hours of empathy training. The empathy training curriculum was divided into three workshops for medical-surgical registered and licensed vocational nurses on one unit; no intervention was prepared or directed at the second unit. Holt-Ashley utilized the Hogan empathy scale in evaluating nurses' empathy levels, and the Risser Patient Satisfaction Scale to evaluate patient satisfaction. Seven weeks after the intervention, nurse empathy levels and patient satisfaction were again evaluated on both units, and pre and postmeasurements of nurse empathy and patient satisfaction were compared. Nurse empathy scores reflected a statistically significant improvement had occurred for the experimental group ($p < .01$), while empathy scores for the control group had actually decreased slightly. Patient satisfaction scores indicated a statistically significant improvement had occurred for the experimental group ($p < .002$), while satisfaction scores for the control group had also decreased slightly.

The results of this study support the researcher's assertion that nurse empathy influences patient satisfaction. However, the study has several serious threats to internal and external validity (Campbell & Stanley, 1963) that render the statistical significance of the results suspect. First, Holt-Ashley did not perform any
activity with the nurse control group. The attention given the experimental nurse group, consisting of 7 hours of empathy training, may have influenced the results. Holt-Ashley should have designed a 7-hour inservice course on an unrelated topic for the control group to minimize the potential of obtaining scores that were the result of the attention given to the experimental group. Second, Holt-Ashley had patients complete their satisfaction tools while still hospitalized. Patients have been known to be hesitant to evaluate their nurses negatively for fear of reprisal or retribution (Nehring & Geach, 1973). Administering the evaluation tool after the patient had been discharged would have been more difficult, but may have provided more accurate results. However, the changes between the pre- and posttest scores on the patient satisfaction instrument are irrefutable and are an important finding. Third, evidence presented earlier in this chapter suggests that having individuals score their own empathy level is not a reliable evaluation of this attribute. While the change between pre- and posttest empathy scores cannot be denied, the nurses may have been responding to the Hogan Empathy Scale during the posttest based on the information they had learned in the empathy training workshops and knew characterized an empathic nurse. The change in a nurse's empathy score does not necessarily indicate a change in behavior. Finally, as
has been discussed earlier, the researcher and others (Jacobs & Williams, 1983) have serious doubts as to whether or not a subjective attribute such as empathy is truly quantifiable.

Holt-Ashley's (1985) study is the only identifiable one to date investigating the effect of nurse empathy on patient satisfaction. However, while enlightening, the strictly quantitative design does not expand our knowledge of the meaning of a nurse's empathy to a patient and how this may impact patient satisfaction.

Other approaches to investigating patient satisfaction are important to review for this study. Two articles describe recent studies in patient satisfaction with nursing care and the hospital experience (Abramowitz, Cote & Berry, 1987; Eriksen, 1987). Study findings by Eriksen (1987) indicated that patients were actually more dissatisfied with their nursing care if the nurses rigidly adhered to policies and procedures without attending to the individualization of nursing care. Patients were discovered to be more satisfied with attendance to nonphysical needs and with those activities that required development of rapport and a relationship between the nurse, a patient, and the patient's family. As a result of this study, Eriksen asserted, "Staff nurses should be aware that patient reports of satisfaction or dissatisfaction may not be equated with the quality of nursing
care they provide" (p. 35). An omission in Eriksen's study pertinent to the present study is the fact that how the nurse performed care and duties was not investigated. Perhaps the empathic nurse performed duties in such a way that the patient was more satisfied with nursing care delivery for various reasons.

Abramowitz et al. (1987) found that overall satisfaction with nursing care influenced the patients' satisfaction with the hospital, in general, and their intent to recommend a hospital to others. "Nurses are the hospital's goodwill ambassadors and frontline representatives. To the extent that nurses cannot fulfill this role, patient satisfaction is severely compromised" (Abramowitz et al., 1987, p. 128). Any dissatisfaction with the hospital environment is channeled through the nursing staff as they are the most accessible hospital personnel. Paramount to patient satisfaction is the patient's perception that the nurse "paid attention" and was "attentive" to the patient's expression of concerns or dissatisfaction with any aspect of the hospitalization. The nurse's ability to attend to and empathize with the patient's concerns and fears, and then act upon this information, was a significant factor in patient satisfaction with nursing care and the hospital experience.

Wren et al. (1971) conducted a patient survey investigating the best time to evaluate a patient's satisfaction
with the hospitalization. They administered 400 questionnaires to four groups of patients. The first group was still in the hospital \((n = 100)\), the second group had been discharged for 1 to 5 days \((n = 100)\). The third group had been discharged for 3 to 5 months \((n = 100)\) and the last group had been discharged 11 to 13 months prior to receiving the satisfaction instrument \((n = 100)\). Wren et al. reported that no difference in the quality and nature of response was noted between the four groups and that the best return rate was obtained from the group still in the hospital. The authors reported few statistics and a sample of the questionnaire was not provided. While not specifically related to nursing care, the results from this study have been used in determining the best time to administer patient satisfaction surveys for nursing studies. Conclusions obtained from this study resulted in most nursing and hospital satisfaction surveys being administered to patients prior to discharge.

The results from the Wren et al. study are contradicted by the findings of Nehring and Geach (1973) who conducted a patient satisfaction survey while patients were still hospitalized. Nehring and Geach found that patients responded to questionnaires in an overwhelmingly positive manner because they were reluctant to complain for fear of reprisal from the nursing staff. Assurances that the investigators were not members of the nursing
staff and that results would be confidential did not appear to convince patients to answer questions in a manner that would have convinced the investigators the patients were answering honestly. Nehring and Geach found the most valid method of assessing patient satisfaction when the patient was still hospitalized was through conducting a taped interview. However, this method had drawbacks, as well. Nehring and Geach reported having difficulty with suspicious nurses and head nurses who would continually interrupt and eavesdrop during the interview process. Patients' poignant anecdotal stories of their own care convinced the investigators that mailed or self-reported questionnaires were not obtaining valid information about the hospitalization as truly experienced by the patient. This researcher concurs with Nehring and Geach's assertion that patient satisfaction surveys do not adequately evaluate the reality of the hospital experience from the patient's perspective. Reviewing the results of this study convinced this researcher that the best method of evaluating patient satisfaction with nursing care would be a tape-recorded interview after the patient had left the hospital and did not need to fear reprisal from the nursing staff.

Kirchhoff's (1976) study of 11 patients discharged from a pulmonary intensive care unit supported Nehring and Geach's findings. Patients reported they were very reluc-
tant to complain about care they received in the hospital for fear of retribution. Kirchhoff concluded that intense scrutiny must be given any patient complaint because this complaint is the "tip of the iceberg" and indicates a much larger problem than the casual comment would indicate.

Kramer (1972) offered a philosophical rationale for the patient's reluctance to personally offer criticism of any aspect the health care system. In her historical analysis of the consumer within the health care system, she acknowledged that recent legislation favoring the consumer has come about not from the health care system's initiative, but from consumer groups. She stated the hospital's tendency to "oil the squeaky wheel" is no longer adequate because "the consumer will always be a buyer in a seller's market," and because "we must recognize and accept the fact that consumers ... need to accept more responsibility for their own health promotion and maintenance" (p. 576). Kramer suggested an attitudinal reorientation for both consumers and providers of health care. Marram (1973) offered an additional reason for the traditionally antagonistic relationship between consumer and health care provider. "... the client in the modern organization is only one source of pressure (for the health care provider) among many, and certainly not the most organized and powerful one" (p. 322). Marram also asserted that a paternalistic attitude is inherent in the
health care system and this attitude is fostered and often accepted by the consumer. This paternalism is a powerful deterrent that prevents consumers from taking a more active role in their hospital experience.

Nurse advocacy of patient and public consumerism in the health care system would create a powerful alliance of two previously undervalued members of the health care system, namely, the recipient of care and the direct caregiver. It is important for nurse administrators to be cognizant of what patients are saying about the care received in hospitals and what can be done to make a hospital experience more positive. In an era of competition for consumers (and, therefore, operating funds), hospitals can no longer afford to ignore what the consumer is saying. The consumer often has a choice of facilities and physicians; the quality of the nursing care at various hospitals may make the difference as to where a patient wishes to be hospitalized. As Abramowitz et al. (1987) observed, "satisfaction with nursing care plays a crucial role in overall satisfaction with a hospital stay and intent to recommend the hospital" (p. 128).

Numerous tools have been developed to measure patient satisfaction with nursing care and hospital experience. The Patient Satisfaction Instrument (PSI), developed from Risser's (1975) instrument by Hinshaw and Atwood (1983), will be discussed in more detail in Chapter II. However,
all tools purporting to measure empathy are subject to the question of reliability and validity in light of the information presented earlier. "Measurement" of empathy, or the positivist's method of evaluating the presence or absence of a phenomenon, may not be possible when attempting to evaluate subjective and affective phenomena.

A review of the literature led the researcher to believe the most reliable data gathering method is the taped interview. The timing of the interview would be important, as Nehring and Geach (1973) described their difficulties when interviewing patients while still hospitalized. The interview would ideally be conducted after discharge to avoid the interruptions and eavesdropping encountered by Nehring and Geach (1973). The tape-recorded interview after discharge would be the most difficult and time-consuming method of gathering information, but it would also gather the richest and most meaningful data of any method discussed in the review of literature.

Conceptual Framework

The subjective and affective nature of empathy indicate that the instruments currently used to measure nurse empathy and patient satisfaction may be lacking construct validity. Construct validity may be thought of as the ability of the tool to measure what it is intended to measure, in this case, empathy (Jacobs & Williams,
1983; Waltz, Strickland & Lenz, 1984). Empathy is best perceived by the patient (Rogers, 1975). However, the patient is reluctant to evaluate the nurse's empathy or nursing care due to fear of retribution (Kirchhoff, 1976; Nehring & Geach, 1973). As stated above, interviews appear to be the most valid indicators of patient experience and satisfaction with hospital care (Nehring & Geach, 1973). Unknown factors undoubtedly influence patient satisfaction with nursing care, as well.

Various demographic variables have been documented to correlate with nurse empathy (Brunt, 1985; Eisenberg & Lennon, 1983; Forsyth, 1979). Empathic nurses may espouse similar philosophies of nursing. Undoubtedly, there are additional other unknown variables and factors that contribute to nurse empathy and patient satisfaction. Gagan stated, "an observatory, exploratory study is suggested to investigate and delineate the precise nature of the empathic process in the nurse-patient relationship" (1983, p. 71). The present investigation was viewed as an initial effort to address Gagan's suggested topic of investigation.

The conceptual framework presented in Figure 1 is an attempt to visually associate the various factors identified in the review of literature -- factors the researcher suspected would influence nurse empathy and patient satisfaction. Survey instruments utilized in this
Figure 1. Conceptual framework.
study are listed after the conceptual framework and are discussed in greater detail in Chapter II.

Summary

In summary, this study had two purposes. The first was to describe what both nurses and patients perceived to be a nurse's empathic behavior. The second was to determine if there was a relationship between the empathy level of the nurse and patient expression of satisfaction with nursing care.

Research Questions

To guide this research, the following questions were developed:

1. What is, and what conveys, empathy as exhibited by the nurse from patient and nurse perspectives? How do these two perspectives compare?

2. What influences patient satisfaction with nursing care from patient and nurse perspectives? How do these two perspectives compare?

3. What is the relationship between empathy as exhibited by the nurse and patient satisfaction with nursing care from patient and nurse perspectives? How do these two perspectives compare?

4. How does information obtained from key leader interviews and artifactual evidence compare to
what patients and nurses say about empathic nurses and patient satisfaction?

5. Is there a relationship between quantitative data and qualitative data obtained about empathic nurses and patient satisfaction with nursing care?
CHAPTER II
DEcIGN AND METHODOLOGY

In this chapter, the design, setting, sampling procedure, and data collection procedures for this study are described. Demographic information about the setting and participants is presented. Data management of both quantitative and qualitative data is also discussed.

Design

A case study design was utilized for this study. A case study design allows critical examination of a phenomenon within a bounded system (Guba & Lincoln, 1982; Stake, 1978; Yin, 1984). It is based on the indepth investigation of an individual, group, or institution. MacDonald and Walker (1977) described a case study as an "examination of an instance in action" (p. 181). For this study, the case under examination was the phenomenon of nurse empathy and patient satisfaction between primary nurses and their patients in a single institution.

Guba and Lincoln (1982) outlined six reasons for the choice of a case study design. First, it provides the reader with a "thick description" that is valuable to human perspective (p. 375). Second, the case study is
grounded and is ideal for the exploration and presentation of data that is grounded and emerges from the study itself. Third, a case study is holistic and lifelike and is easily understood and credible to the reader and participants. Fourth, a case study serves to simplify the presentation of data anecdotally rather than in technical tables and graphs. Fifth, a case study presents the reader with a "well-integrated statement" that elaborates relationships and allows the reader to focus on the important aspects of the study. Finally, and perhaps most applicable in this instance, a case study builds on what Polanyi (1958) identified as "tacit knowledge." Tacit knowledge means the intuitive and historical experience of the individual is called upon to assist in understanding and ascribing meaning to the information presented. As Guba and Lincoln stated, "We all know more than we can say; the case study provides a vehicle for the transference of that kind of wordless knowledge" (p. 377). Each of the above reasons will be addressed in regards to their applicability to this study.

Guba and Lincoln's first point, that of providing the reader with a "thick description," was applicable in this case because current methods of describing and explaining nurse empathy and patient satisfaction seem to be two-dimensional and generally lack depth. The second point, that of the case study being grounded and the proposed
emergence of data from the study was applicable to this study because current understanding of the relationship between nurse empathy and patient satisfaction with nursing care is limited. While Holt-Ashley (1985) conducted a study that demonstrated a positive relationship between nurse empathy and patient satisfaction, this study used quantitative tools and methods. A case study would facilitate the discovery of more meaningful information about the relationship between nurse empathy and patient satisfaction. A conceptual framework was created based on information presented in Chapter I, but much more information emerged through thoughtful analysis of interviews and questionnaires. While the case study may not be grounded in the sense Glaser and Strauss (1967) first introduced the term, this study was somewhat grounded because there is more to be known about the relationship between nurse empathy and patient satisfaction. This study was exploratory in the sense that the data presented were grounded; that is, the data were emic and emerged from data analysis.

Guba and Lincoln's third point, that of the case study being holistic and lifelike, has a special meaning for this study. As current empathy and patient satisfaction evaluation methods involve paper-and-pencil questionnaires, a case study will add more depth and a more human perspective to this area of inquiry.
Fourth, a case study relies more heavily on presentation of data anecdotally and the researcher found that the interviews conducted in this study yielded information that added life and depth to the concept of empathy. Interviews with nurses and patients yielded information about what patients perceive as important to their ultimate satisfaction with nursing care in a hospital setting. Additionally, interviews with key leaders and artifactual data yielded information supporting nurse and patient observations about nurse empathy and patient satisfaction.

The fifth reason, presenting a well-integrated statement for the reader is applicable as the results of this study should allow the reader to gain a better understanding of the relationship between nurse empathy and patient satisfaction because these observations emerged from the data collected. Finally, and most importantly, the results of this study speak eloquently about the phenomena of nurse empathy and patient satisfaction. By using the "tacit knowledge" Polanyi (1958) alludes to, the results from this study should be easily understood and it is hoped that they will be integrated into current nursing knowledge and practice to improve patient care.

Stake (1978) observed that case study methods "will often be the preferred method of research because they may be epistemologically in harmony with the reader's exper-
ience and thus to that person a natural basis for general-
ization" (p. 5). He further stated that a case study
allows the reader to apply a "naturalistic generalization" to a phenomenon and, thereby, recognize "the similarities of objects and issues in and out of context" (p. 6). The case study design is appropriate where the researcher is interested in adding to the existing experience and human-

istic understanding of a phenomenon. Stake (1978) said,

Intentionality and empathy are central to the comprehension of social problems, but so also is information that is holistic and episodic. The discourse of persons struggling to increase their understanding of social matters features and solicits these qualities. And these qualities match nicely the characteristics of the case study. (p. 7)

Guba and Lincoln (1982) indicated the case study approach might be most applicable in studies where the re-
searcher proposes to "render, that is, to depict or characterize" (p. 371). Guba and Lincoln's typology identified three levels of the case study: a factual level, an interpretive level and an evaluative level. At the factual level, with the intent of rendering a phe-
nomena, the researcher would "construct and the products are profiles" (p. 373). At the interpretive level, the researcher would "synthesize" information, and the product would be "meanings" of the phenomena under scrutiny. At the evaluative level, with the intent of rendering a phe-
nomena, the researcher would "epitomize and the appro-
priate products of the rendering ... are portrayals" (p.}
For an exploratory and descriptive study, Guba and Lincoln's description of a case study to "render" seemed most apt. The researcher was attempting to construct a profile of nurse empathy and patient satisfaction through the selection of a case study setting that would allow for optimal levels of the phenomena being investigated.

Yin (1984) identified a case study as a design of choice when the investigator is curious about "A 'how' or 'why' question (that) is being asked about a contemporary set of events, over which the investigator has little or no control" (p. 20). Yin stated that a distinct advantage of the case study is the ease with which the researcher may utilize numerous sources of evidence (p. 23) and that these numerous sources of evidence serve to address potential problems of construct validity as they "essentially provide multiple measures of the same phenomenon" (p. 91). A case study design was thereby deemed most appropriate as this researcher used multiple methods and measurements of the phenomena of nurse empathy and patient satisfaction.

**Limitations of the Design**

Any study design will have limitations, and a case study is no exception. Some concerns about a case study design are that it lacks scientific rigor and validity in the quantitative, experimental sense (Guba & Lincoln, 1982; House, 1980; Patton, 1980; Yin, 1984). The purpose of a case study, however, is to explore phenomena un-
bounded by experimental restrictions. It is not appropriate to impose a quantitative, logical positivist paradigm on a qualitative, holistic study design and data collection method. For the purposes of an exploratory and descriptive study with a qualitative concept such as nurse empathy, a case study was a logical design, as was examining a case that is anticipated to represent an ideal situation.

There is the threat of the researcher exhibiting what Miles and Huberman (1984) identified as "holistic fallacy" and "going native" (p. 230). The threat of going native was the most applicable to this study because the researcher is a practicing nurse. To prevent the possibility of going native, the researcher acted as an observer only, not as a participant-observer which would have considerably increased the risk of going native. The threat of "holistic fallacy," or losing perspective and allowing initial observations to alter the researcher's perspective on additional observations, was mitigated by the participants and the researcher's data. The participants let the researcher know if she was pursuing a line of questioning that participants did not find valuable or meaningful to the topics of discussion. The taping of interviews and transcription of those tapes presented the researcher with the verbatim text in black and white where inconsistencies could not be ignored.
Setting

The setting for this case study was purposefully chosen for various characteristics that were hypothesized to make this hospital the best available setting to examine nurse empathy and patient satisfaction. Each criterion will be identified followed by a discussion of how the study facility met these criteria. The study facility, a 465-bed tertiary care hospital, met every criterion and is located in the northeastern United States.

Criterion 1: Stable nursing administration and philosophy for over 10 years at the study facility. The study institution has had stable nursing administration under the same Vice President for Nursing for over 15 years. The hospital's original nursing philosophy was developed 14 years ago and has undergone periodic refinements since that time.

Criterion 2: All registered nurse staff at the bedside delivering direct patient care. The study facility employs 1189 nurses and has a predominantly registered nurse (RN) staff. Of all nurses working at the facility during the data collection period, 86% held baccalaureates as their original nursing degree, with a total of 92.8% holding baccalaureate or higher degrees; 15.8% held master's degrees in nursing; and the remaining 7.2% of nursing staff were prepared at the diploma or associate degree level. The facility is committed to hiring only
baccalaureate-prepared nurses and nurses currently working within the study facility without baccalaureate degrees had begun their employment prior to the development of the current nursing philosophy.

Criterion 3: Nurse vacancy rate of less than 5%. In 1988, the national vacancy rate, that is, the number of nursing positions currently unfilled, was 13-14%. (Scherer, 1988). The study facility's nurse vacancy rate during February 1989 (the period of time the researcher was conducting this study) was 0.51 percent.

Criterion 4: Low nurse turnover rate, thereby indicating a pool of stable caregivers who are familiar with the institution's mode of care delivery and are experienced in patient care. In 1988, it was reported that there were five nurse applicants for every nursing position available (American Hospital Association, 1988). Data available to the researcher indicated that in fiscal year 1988-1989, the RN turnover rate was 10.2%. This turnover rate was considerably less than the 23% recorded for fiscal year 1980. Further information available indicated the longevity of the average RN on a medical/surgical unit was 3.3 years, or 39.2 months. Staff tenure for all nursing departments indicated that 20.2% of all nurses had been working at the study facility for less than 1 year, 31.0% had worked from 1 to 3 years, 16.7% had worked from 3 to 5 years, 8.2% had worked from 5 to 7
years, 9.7% had worked from 7 to 10 years, 6.9% had worked from 10 to 14 years, 4% had worked from 15 to 20 years, and 2.3% had worked at the study facility for 20 years or more.

Criterion 5: Primary nursing as a standard mode of care delivery and functioning in an uninterrupted fashion for 10 years or more. The study facility's registered nurses have been practicing primary nursing as a mode of care delivery since 1975 (Hegedus, 1979).

Criterion 6: A nursing research committee or department and nursing staff that value and advocate ongoing and innovative nursing research projects. The study institution has an active Nursing Research Review Committee that approves nursing research proposals before they are forwarded to the hospital's Committee on Clinical Investigation; the nursing staff is accustomed to the presence of nurse researchers and participates in a number of nursing research projects annually (M. Williams, Chairperson of Committee on Clinical Investigation, personal communication, 30 June 1988).

Criterion 7: A Magnet Hospital as identified in the Magnet Hospitals study conducted by the American Academy of Nursing Task Force on Nursing Practice in Hospitals in 1983 (McClure, Poulin, Sovie & Wandelt, 1978). The study facility is a Magnet Hospital and is known for innovation and excellence in nursing practice and high quality

Criterion 8: No previous experience with this institution by the researcher. This researcher had no personal experience with the study institution, meaning that she had not been an employee or patient at this institution.

An additional reason for selection of this facility was the researcher's familiarity with the institution's home city and environs. This familiarity with the region was helpful because part of the data gathering process involved home visits with discharged patients.

Sampling Technique

A purposive sampling procedure was utilized for this exploratory study (Lincoln & Guba, 1985; Miles & Huberman, 1984; Patton, 1980). A purposive sample is one in which the researcher carefully chooses the sample most likely to yield either troublesome or enlightening results. Patton (1980) stated, "Decision makers and evaluators think through what cases they could learn the most from, and those are the cases that are selected for study" (emphasis in the original) (p. 100).

Looking for the critical case is particularly important where resources may limit evaluation to the strategic sense to pick the site that would yield the most information and have the greatest impact on decision maker actions and understanding. (Patton, 1980, p. 103)

By choosing an ideal setting and seeking a purposive
sample, the researcher was able to identify what factors were perceived by nurses and patients as communicating empathy and how empathy affected patient satisfaction with their nursing care. In their characterization of sampling for qualitative methodologies, Miles and Huberman stated,

qualitative researchers usually work with smaller samples of people in fewer global settings than do survey researchers. Also, qualitative samples tend to be more purposive than random in nature, partly because the initial definition of the universe is more limited... (emphasis in the original). (1984, p. 36).

Nurse and patient participants were sought from all adult nursing units with the exception of the intensive care units where the patient population was hypothesized to be less aware of their surroundings and nursing care. Pediatric units and nurseries were not included in the study to create a more homogeneous sample and, thus, increase trustworthiness of the resulting data (Patton, 1980).

**Purposive Sample**

The population studied was limited to employees and patients at the study institution. The sample criteria are discussed below. Inclusion in the study also relied upon the individuals' ability to collaborate with the researcher by participating in this study during the 2 month period that the researcher was available to interview study participants and collect data.
Nurse participants were limited to those working in general adult medical, surgical, or specialty units. Once these units were identified, Nurse Managers of the units were contacted. Access to Nurse Managers was obtained through Assistant Directors of Nursing. Nurse Managers nominated nurses on their units for possible participation in this study.

To be included in the study, registered nurses needed to be employed more than 20 hours per week (more than 50%) on their designated unit and to have been employed at the study institution for a minimum of 1 year. In meeting these criteria, nurses would be familiar with the hospital (not adapting to a new system) and would be delivering patient care often enough to work extensively with their patients and develop a nurse-patient relationship.

Sixteen nurses from nine inpatient units were approached and agreed to participate in the study. All nurses agreed to participate and expressed interest and enthusiasm for the topic of discussion. One nurse approached the researcher and volunteered to participate when she had heard about the study from a colleague who was a study participant. While this nurse was not nominated by her nurse manager, her interest in the subject matter and motivation to participate in the study presented the researcher with the opportunity to interview a
self-selected participant who offered a different perspective on the subject.

A total of 17 nurses from nine units participated in the study. While 17 nurses originally participated in this study, a final total of only 12 nurses from six units was included in this study because this project required matched nurse-patient pairs. Researcher time constraints, nurse vacations, and other factors prevented patient matches for 5 nurses.

The 5 nurses without patient matches were similar demographically to the 12 nurses included in the study, with the exception of one nurse who was a 22 year veteran of the study facility and had seen the advent of primary nursing first-hand. This nurse was the only nurse to have less than a baccalaureate degree; she had an associate degree in nursing. A patient match was not available for this nurse because although she worked 3 days a week, she usually served as the unit's clinical resource and did not routinely admit and care for primary patients.

Demographically, the 12 nurses in this study were an extremely homogeneous group. Demographic information is presented in Table 1. All nurses interviewed were female. The typical nurse was in her mid-20s, single, and educated with a baccalaureate degree in nursing. Nurses ranged in age from 23 to 32, with an average age of 26.3. Eight
Table 1
Demographics of Nurse Participants

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Children</th>
<th>Yrs. Experience</th>
<th>Specialty</th>
<th>No. of Hospitalizations</th>
<th>Family Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>N001</td>
<td>24</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>2.5</td>
<td>Med/Surg</td>
<td>One</td>
<td>Yes</td>
</tr>
<tr>
<td>N002</td>
<td>32</td>
<td>F</td>
<td>Married</td>
<td>None</td>
<td>2.5</td>
<td>Med/Surg</td>
<td>One</td>
<td>Yes</td>
</tr>
<tr>
<td>N004</td>
<td>25</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>1.5</td>
<td>Med/Surg</td>
<td>One</td>
<td>Yes</td>
</tr>
<tr>
<td>N005</td>
<td>31</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>10.5</td>
<td>Oncology</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>N008</td>
<td>26</td>
<td>F</td>
<td>Married</td>
<td>None</td>
<td>3.5</td>
<td>Gyn/Surg</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>N009</td>
<td>24</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>2.0</td>
<td>Med/Surg</td>
<td>Two</td>
<td>Yes</td>
</tr>
<tr>
<td>N010</td>
<td>25</td>
<td>F</td>
<td>Married</td>
<td>One</td>
<td>3.5</td>
<td>Med/Surg</td>
<td>One</td>
<td>None</td>
</tr>
<tr>
<td>N011</td>
<td>25</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>3.5</td>
<td>Surgery</td>
<td>One</td>
<td>Yes</td>
</tr>
<tr>
<td>N014</td>
<td>23</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>1.5</td>
<td>Med/Surg</td>
<td>One</td>
<td>Yes</td>
</tr>
<tr>
<td>N015</td>
<td>26</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>3.5</td>
<td>Med/Surg</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>N016*</td>
<td>31</td>
<td>F</td>
<td>Single</td>
<td>None</td>
<td>2.5</td>
<td>Oncology</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>N017</td>
<td>24</td>
<td>F</td>
<td>Married</td>
<td>None</td>
<td>2.5</td>
<td>Med/Surg</td>
<td>None</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note. *All nurses had 16 years of education (12 years plus baccalaureate degree), except this nurse, who had 18 years of education.
nurses (66.7%) were single and 4 nurses (33.3%) were married; 1 nurse had one child.

All nurses had a minimum of a baccalaureate degree, and 1 nurse had a master's degree in nursing for nonnursing baccalaureate majors. This 1 nurse had a baccalaureate degree in biology and returned to school for her nursing master's when she decided upon a career change.

Years of nursing experience ranged from 1.5 years to 10.5 years, with average years of experience being 3.29 years. Nine nurses (75%) had between 2 and 4 years of nursing experience, 2 nurses had only 1.5 years of nursing experience, and 1 nurse had 10.5 years of experience. The study facility recognized different clinical levels for nursing staff. One nurse participant was a Level I, 7 nurses were Level IIIs, and 4 nurses had achieved a Level III. Eight nurses (66.7%) worked on medical or surgical units, 2 nurses (16.7%) worked on gynecology/surgery units, and the remaining 2 nurses (16.7%) worked on oncology units.

In response to a question asking if they had ever been hospitalized personally, 6 nurses (50%) had been hospitalized once, 1 nurse (8.3%) had been hospitalized twice, and 5 nurses (41.7%) had never been hospitalized. Eleven (91.7%) nurses had personal experience with the hospitalization of family members. The 1 nurse who had not had a family member hospitalized had been hospitalized
once. Therefore, all 12 nurse participants (100%) had personal and/or family hospital experiences.

Patients

Nurse participants nominated patients who might be interested in participating in this study. The criteria for patient participation were outlined for nurse participants, namely that the patient needed to be of legal age, be in the hospital a minimum of 3 days, and be cared for by the nurse participant for a minimum of three shifts. The patient also needed to identify his or her nurse participant by name.

Fifteen patients were approached for inclusion in the study. Three patients declined participation either upon initial contact or after discharge. Reasons cited by patients for not participating in the study included that they "lived too far away," that they "were not interested" in participating in a study, or that they did not want the researcher coming to their homes. Twelve patients participated in the study, forming 12 nurse-patient pairs. Demographic information of the 12 patient participants is presented in Table 2.

Demographically, the patient participants were as diverse as the nurse participants were homogenous. Patients ranged in age from 19 to 73, with the average age being 49.2. Eight (66.7%) patient participants were female and 4 (33.3%) were male. Eight participants
Table 2

Patient Demographics

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Children</th>
<th>Education (yrs)</th>
<th>Hospitalizations</th>
<th>Length of Stay (days)</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>P001</td>
<td>59</td>
<td>M</td>
<td>Married</td>
<td>3</td>
<td>12</td>
<td>1-10</td>
<td>10</td>
<td>Multiple Myeloma</td>
</tr>
<tr>
<td>P002</td>
<td>63</td>
<td>F</td>
<td>Divorced</td>
<td>4</td>
<td>18</td>
<td>1-10</td>
<td>13</td>
<td>Cancer, Mets</td>
</tr>
<tr>
<td>P004*</td>
<td>73</td>
<td>F</td>
<td>Married</td>
<td>0</td>
<td>17</td>
<td>1-10</td>
<td>14</td>
<td>Cancer, Spleen</td>
</tr>
<tr>
<td>P005</td>
<td>35</td>
<td>F</td>
<td>Married</td>
<td>0</td>
<td>12</td>
<td>1-10</td>
<td>7</td>
<td>Leukemia</td>
</tr>
<tr>
<td>P008b</td>
<td>30</td>
<td>F</td>
<td>Married</td>
<td>0</td>
<td>12</td>
<td>1-10c</td>
<td>5d</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>P009c</td>
<td>54</td>
<td>F</td>
<td>Married</td>
<td>4</td>
<td>8</td>
<td>&gt;20</td>
<td>8</td>
<td>Respiratory Insufficiency</td>
</tr>
<tr>
<td>P010</td>
<td>39</td>
<td>M</td>
<td>Divorced</td>
<td>0</td>
<td>13</td>
<td>1-10</td>
<td>12</td>
<td>Hodgkin's Disease</td>
</tr>
<tr>
<td>P011f</td>
<td>61</td>
<td>F</td>
<td>Married</td>
<td>3</td>
<td>12</td>
<td>1-10</td>
<td>10</td>
<td>Vulvar Cancer</td>
</tr>
<tr>
<td>P014</td>
<td>65</td>
<td>F</td>
<td>Married</td>
<td>2</td>
<td>12</td>
<td>1-10</td>
<td>13</td>
<td>Lymphoma</td>
</tr>
<tr>
<td>P015</td>
<td>42</td>
<td>M</td>
<td>Single</td>
<td>0</td>
<td>16</td>
<td>1-10c</td>
<td>17</td>
<td>AIDS/CPC</td>
</tr>
<tr>
<td>P016</td>
<td>19</td>
<td>F</td>
<td>Single</td>
<td>0</td>
<td>12</td>
<td>&gt;20</td>
<td>42</td>
<td>Hodgkin's/BMT</td>
</tr>
<tr>
<td>P017g</td>
<td>50</td>
<td>M</td>
<td>Married</td>
<td>5</td>
<td>12</td>
<td>1-10</td>
<td>9</td>
<td>Renal Transplant</td>
</tr>
</tbody>
</table>

Note. *Retired registered nurse; bformer nurses' aid; cfirst admission; d5 days X 2; eniece is registered nurse; ftwo daughters are registered nurses; gmother, wife, and daughter are registered nurses.
(66.7%) were married, 2 (16.7%) were single, and 2 (16.7%) were divorced. Half of the participants were parents of two to five children, with the average number of children per participant being 1.75.

Patient participants averaged 12 years of education, with an actual range of 9 to 18 years. Five patients (41.7%) had completed high school, and 2 (16.7%) had completed college or postgraduate educations. The remaining 5 patients (41.7%) had completed high school plus 1 to 3 years of higher or vocational education. Ten patients (83.3%) had been hospitalized prior to this hospitalization, and 2 (16.7%) were experiencing their first hospitalizations at the time of this study. Of those 10 patients who had been previously hospitalized, 8 had been hospitalized 1 to 10 times, and 2 had been hospitalized over 21 times in the past.

Interestingly, 5 of the 12 patients had personal experiences with nursing or with nurses being in their immediate or extended family. One patient was a retired nurse who had asked this information not to be passed on to her caregivers. When the researcher spoke to the patient to obtain her permission for participation in this study, she confided in a whisper to the researcher, "I'm one of you, you know. I'm a nurse!" Another patient had some experience as a nurse's aid in another local facility. Another patient's mother, wife, and daughter were
nurses. A different patient's two daughters were nurses, and yet another patient's niece was a nurse. While this information was not purposefully sought, all 5 of these patients used their personal or family experiences to help them describe positive or negative examples of nurse empathy.

Key Leaders

Key leaders were interviewed to provide another dimension and additional insight about nurse empathy and patient satisfaction. Key leaders were identified by their administrative title and affiliation to nursing practice. Prior to data collection, the key leaders were identified as the Vice President for Nursing, the hospital President and various Directors of Nursing (i.e., Medical Nursing and Surgical Nursing). Individuals were considered to be key leaders if they influenced the hospital's nursing philosophy and the delivery of nursing care.

Twelve individuals identified as key leaders were interviewed. Ten leaders were nurses in managerial or consultative positions. Two leaders were nonnurses and were involved in nurse recruitment and hospital management. The originally anticipated number of 1-5 leaders grew to 12, based on information gained from informants and after more careful scrutiny of the decentralized administrative structure.
Instruments

In this section, the instruments used during the data collection phase of this study will be described. Two tools were developed by the researcher. The three remaining tools were developed by others and are described below.

Interview Schedule

Two semistructured interview guides, one each for nurses and patients, were developed by the researcher to explore nurse empathy and patient satisfaction (Appendix B). The interview guides were pilot tested with 2 nurses and 1 patient for ease of understanding, approximate times for completion, and equipment function. Refinements were made to the interview guides based on information gained from the pilot sessions. The guides were designed to follow the research questions.

The semistructured interview was chosen to allow the researcher to investigate interesting and pertinent information volunteered by the participant. When investigating a phenomenon such as empathy, different participants may express what might be interpreted as empathy in different ways. A semistructured interview allowed the researcher to help the participant elaborate on concepts.

It has been noted that patients may frequently be unsatisfied with care received during their hospitalization due to circumstances beyond the nurse's control.
Patients may wish to elaborate upon these non-nurse incidents as they may have been distressing at the time. A semistructured interview allowed the researcher to refocus and redirect the interview if the patient digressed to situations or instances not pertinent or related to nursing or nursing care or explore how patients perceived these events as related to nursing care.

The researcher relied on her skill as a nurse and interviewer to determine the best questions to explore the subject under scrutiny. Nurses perform interviews in their daily patient care practice. As Diers (1979) noted, "nurses use interview techniques all the time, whether they realize it or not, because a large part of nursing depends on getting certain information from the patient" (p. 254). Questions were open-ended and the researcher made every attempt to avoid dichotomous or leading questions during interviews.

**Barrett-Lennard Relationship Inventory**

In addition to the interviews, data were collected using the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1978). The BLRI is a 64-item instrument designed to measure congruency in helping relationships. Sixteen questions from this 64-item tool comprise the empathy subscale of the BLRI. Barrett-Lennard developed the
original tool in 1957 and has refined it most recently in 1978. The empathic understanding component of the tool is said to have been reliable in 1957, although no alpha coefficients or statistical validation of this were presented (Barrett-Lennard, 1962). Statistical reliability and validity measures were not found in the 1978 revision of the tool. Originally designed to evaluate the therapist/counselor-to-client relationship, the most recent adaptation allows the tool to be applied in circumstances in which two individuals are involved in a helping relationship.

The BLRI has been developed with two mirror components; the BLRI-OS (Others toward Self), and the BLRI-MO (Myself toward Others). The BLRI-MO was administered to each nurse to determine how the nurse felt toward the patient. The mirror component, the BLRI-OS, was administered to the patient to determine how the patient perceived the nurse.

The BLRI as a measure of nurse empathy has been used in nursing studies since 1971. Gagan (1983) noted that, "Except for the Kalisch study in 1971, use of the BLRI in nursing studies has predominantly occurred within the last 2 years" (p. 69). Stetler (1977) suggested that the BLRI is the most conceptually valid measure of empathic ability. Barrett-Lennard (1962) documented that there is a positive correlation between psychiatric patient improve-
ment and high scores on the empathy subscale of the BLRI. Gagan (1983) reported this as evidence that the BLRI's strategy of having patients rate caregivers is, thus, conceptually sound. However, Gagan also pointed out that because the BLRI has been formulated for use with therapist-client populations and not hospital populations, there may be a fundamental construct validity flaw in the application of the BLRI to hospital settings.

The BLRI was used in data collection for this study because it is the only tool that compares helper perceptions with helpee perceptions. It was also chosen because it has been used in recent nursing studies, is short and is easily understood by participants.

LaMonica Empathy Profile

The LaMonica Empathy Profile was administered to nurse participants. LaMonica (1986) developed this tool from a refinement of her earlier Empathy Construct Rating Scale (1978). LaMonica, a nurse, was interested in the concept of empathy in general and nurse empathy in particular. Although the LEP is a recently developed tool (1986), it is the only empathy rating tool currently available that was developed by a nurse and has a historical development of use by and for nurses.

Due to the recent development of the LEP, there is no available data on its use in studies other than those conducted by the creator of the instrument. LaMonica
developed the tool from over 200 pooled questions generated by graduate students and a separate panel of experts. The resulting pool of questions was reassessed and a final tool, the LEP, emerged. (LaMonica, 1986) LaMonica reported a "high internal consistency" with the items on the LEP, with an alpha coefficient on the self-rating scale of .96 (N = 300). There are no published studies to date that identify use of the LEP as a method of data collection.

LaMonica divided her 30 item tool into five subscales. They are: nonverbal behavior; perceiving feelings and listening; responding verbally; respect of self and others; and openness, honesty, and flexibility (LaMonica, 1986). Each of these scales' totals vary with the number of responses in each subscale. For instance, a high score in one area will produce a correspondingly lower score in all other areas. When adding the sums of all the subscales, the total score for the tool will remain the same no matter how the participant ranks in each subscale. With the LEP, as with other tool scores, it is necessary to have a resulting total numerical score that may vary with each participant. A proposed adaptation to the LEP, made by LaMonica to consultants at the University of Utah (P. Gaspar, M. Casserta, June 1988), would be to allow the respondent to choose one of two statements as that being the one most like them and subsequently rating that statement on a 6-point Likert scale. In this way, a total
numerical score might be obtained and then used for correlation with other measures used in this study. It is uncertain how this alteration will affect the validity and reliability of the instrument, as this adaptation of the tool has not been attempted in the past.

Diers (1979) identified five considerations when evaluating the validity of tools. They are construct validity, concurrent (or criterion-related) validity, content validity, face validity, and predictive validity. From the information available, LaMonica developed the LEP using face validity or expert opinion as a primary validity measure. Construct validity was addressed when LaMonica had participants use the tool to rate the least empathic person they knew. It was not mentioned in the literature available with the LEP if LaMonica compared the data obtained from the LEP with other measures of empathy other than her own, previously developed tool (concurrent validity), or if the items were verified from sources other than the panel of experts (content validity). There was also no mention of the LEP being compared with other factors that empathy might predict, such as helper effectiveness (Barrett-Lennard, 1962; Rogers, 1975) or creativity (predictive validity) (Stotland et al., 1978).

Reliability of tools, according to Diers (1979), is dependent upon three general criteria. First, the measurement must be stable. Second, the measurement must
be consistent; and third, there must be an equivalency of instruments. LaMonica documented that the tool seems to be stable and consistent through various testing populations (LaMonica, 1986). There was no mention of comparing the LEP to another instrument that might provide an equivalent measure of empathy.

This tool was chosen for use in this study as it was the only tool developed by a nurse to measure empathy and because it was a relatively new tool. The researcher saw, and chose to take, this opportunity to advance knowledge about the use of the LEP with nurses in a practice setting.

**Patient Satisfaction Instrument**

The third tool, Hinshaw and Atwood's (1983) adaptation of Risser's patient satisfaction scale (1975), was administered to all patients participating in the study. Hinshaw and Atwood have documented the development of this tool, the Patient Satisfaction Instrument, through administration of the tool to 600 patients. Ward and Lindeman (1978) identified Risser's tool as the most reliable in their comparison of four patient satisfaction evaluation tools and methods. The tool has three subscales: the Educational, Trust, and Professional subscales. The "trust" subscale is of particular interest to this study. The entire 25-item tool was administered and responses were based on a 5-point Likert-like scale,
The Risser Patient Satisfaction Scale was developed by a nurse practicing primary care in an outpatient setting (Risser, 1975). Ward and Lindeman (1978) evaluated the instrument and stated that the scale had been soundly designed and tested, that reliability is good, and there is some evidence of validity. Risser divided questions in the 28-item tool into three subscales: "interpersonal-trusting," "technical-professional," and "interpersonal-educational" satisfaction with nursing care.

Hinshaw and Atwood's refinement (1983) of Risser's tool has been assessed for internal consistency. Alpha coefficients for each subscale were greater than .780, and the PSI was subjected to further statistical analyses to determine construct validity. Overall, Hinshaw and Atwood determined the PSI had acceptable levels of validity and reliability. However, they noted "a question remains as to the three aspects of patient satisfaction being indexed" (p. 1). As the Hinshaw and Atwood adaptation of Risser's tool is the latest refinement on a reliable tool, the PSI was used to collect information on patient satisfaction.

Demographic Questionnaires

Two single-page demographic questionnaires were developed for nurses and patients (Appendix C). These questionnaires were developed to gather information about the participants' sex, age, educational level, marital,
and parental status that correlated with levels of empathy in earlier cited studies. Nurses were also asked if they or a loved one had ever been hospitalized, with the thought that this experience might increase their empathic ability. Patients were also asked how many times they had been hospitalized with the thought that prior experience with hospitals and nurses that might influence expectations of and responses to the nurse-patient relationship. Patients were also given the opportunity to request an abstract from the finished work via a tear-off section at the bottom of their demographic sheet.

Data Collection Procedure

Permission to conduct the study was obtained through the University of Utah's Institutional Review Board, the study institution's Nursing Research Review Board, and the Committee on Clinical Investigations. As is the custom with outside researchers, the study facility's Nursing Research Review Board assigned two preceptors to the researcher to be available to answer questions and facilitate the study. The two assigned preceptors were the directors of medical nursing and nursing research.

Nurses

Upon arrival at the study site, the two assistant directors of nursing of the medical and surgical units were contacted and arrangements made to attend their next
nurse manager group meetings. At both nurse manager meetings, the researcher introduced herself and explained the purpose of her study. The researcher outlined the criteria for participation by nurses and nurse managers were requested to list 3 to 5 nurses on their unit who they thought were especially empathic and who were able to work effectively with patients and families other nurses might perceive as being "difficult." Nurse managers readily responded with 3 to 6 names.

The researcher contacted the person with the first name on each nurse manager's list of nominated nurses, with the thought that if this was the first nurse who came to the nurse manager's mind, this nurse would most likely be the best candidate for the study. Once a nurse from each participating unit was involved in the study, the researcher randomly chose another name from each unit from the nurse manager's list and invited them to participate in the study.

Letters inviting the nurses to participate in a study were hand delivered to each nurse's mailbox on their home unit (Appendix A). This letter was followed by a personal visit and/or phone call to the home unit to ascertain the nurse's interest and willingness to participate in the study. When the nurse agreed to participate, a mutually satisfactory interview time and place was scheduled and they were given the two questionnaires (BLRI-MO and LEP)
and the nurse demographic data sheet. The nurses were instructed to complete these three items before the scheduled interview time to facilitate discussion during the interview. The nurses were interviewed 3 or more days after being given the questionnaires.

The researcher used the semistructured interview guide described above as a framework for discussion (Appendix B). Interviews were conducted in a quiet room, usually a conference room or office. A "Do Not Disturb -- Interview in Progress" sign was taped to the door during interviews in an attempt to prevent disruption. One hour was scheduled for the interview and this time limit, plus or minus 5 to 10 minutes, was adhered to for all nurse interviews. The initial portion of the interview was spent answering questions about the questionnaires, the researcher and the researcher's topic of interest. Interviews were tape recorded and later transcribed. The researcher made field notes immediately following the interview to note setting, appearance, and nonverbal cues from the nurse to add more depth to the transcribed tapes.

At the close of the interview, participating nurses were told the criteria for patient participants in the study and asked if they currently had any primary or associate patients in the hospital who fit the criteria and might be interested in participating in a study. If the nurse could not nominate a patient at that time, the
researcher checked back every few days until a patient was nominated or the researcher's time limitations precluded including another patient participant.

**Patients**

As mentioned, patient participants were nominated by their corresponding nurse participants. Nurses were encouraged to nominate a primary patient of theirs if possible, but many nurses did not have a primary patient at the time of the study, and in these cases, a primary nurse-patient match was not possible. If the nurse could not nominate a primary patient, a close associate patient was nominated. Some nurses referred to these patients as "co-primes," or co-primary patients. Nurses recommended patients who they believed would be interested in and open to participating in a research project.

Patients were approached for participation in the study while they were in the hospital and anticipating discharge within a few days. The researcher introduced herself, told where she was from, and explained her reason for speaking with them. Every care was taken not to identify the researcher as a nurse. This was done because it was feared the patient would associate the researcher with the study facility and with the nursing staff and this association would inhibit honest and spontaneous patient discourse. Patients were asked if they were willing to participate in a study about nurses' empathy and their
satisfaction with the hospital experience. The informed consent (Appendix A) letter was left with patients who were unsure at that time if they wanted to participate in the study, and the researcher visited them a second time to answer any questions or concerns about the study.

Once the patient had agreed to participate in the study, one informed consent form complying with the study facility's requirements (Appendix A) was given to the patient and another signed copy was placed in the patient's chart. A letter from the researcher to the patient's physician was also placed in the chart to inform the physician that the patient had agreed to participate in a nursing research study. The researcher's local address and phone number were included in this letter. The researcher did not receive any physician inquiries about the study.

After the patient had been discharged, copies of the survey instruments were sent to the patient at their home or recuperative address, with a cover letter that included the researcher's local phone number and address and reminded them of the intent and nature of the study. The researcher called the patient within 1 week after discharge to arrange a time and place for the interview and answer any questions they may have had about the survey instruments. Patients were interviewed between 3 days and 6 weeks after discharge. The wide variance in time between
discharge and interview was because of researcher time limits, and 1 patient's relapse and subsequent admission to another hospital 3 days after her discharge from the study facility.

The study facility is a regional referral center for many unusual disorders. As a reflection of this reputation, patient participants lived in three different states surrounding and including the study facility's home state. The researcher traveled from 1 mile to 200 miles away from the study facility to interview patients.

Eight patients were interviewed in their own homes, and 3 were interviewed at the hospital in a reserved conference room when they returned for clinic visits. One patient was interviewed at her son's home where she was recuperating. The researcher was sensitive to patient cues of discomfort and fatigue and used these cues to determine the length and content of interviews.

Ten patients had completed the quantitative instruments before the interview. Two patients had had some difficulty understanding the questions and completed the instruments during the researcher's home visit, prior to the interview taking place. The researcher used a semistructured interview guide (Appendix B) similar to that used with the nurse participants and the interviews lasted from 3/4 of an hour to 1 1/2 hours. Interviews were tape recorded and later transcribed. Following the
interview, the researcher made field notes describing setting, tone, and nonverbal cues of the patient that would not be picked up on tape.

Key Leaders

As mentioned, key leaders were identified by their administrative title and affiliation to nursing practice. The study institution's leaders were the first to be approached for inclusion in the study after the researcher arrived at the study site due to their accessibility and reliable schedules. Identified key leaders were contacted and convenient interview times were arranged. Interviews were conducted in the leaders' offices.

No interview guides were used during these interviews so the researcher could focus the questions on the concepts of nurse empathy, patient satisfaction, and the individual leader's role with and influence over the nurse-patient relationship. Interviews lasted from 20 minutes to 1 3/4 hours, with one interview taking place in two sessions due to scheduling conflicts. The interviews were taped for later transcription. Again, the researcher made field notes immediately following the interview to add pertinent information regarding affect, nonverbal cues, and surroundings during the interview.
Artifactual Information

A case study design allows the researcher to explore unusual and varied sources of information that are not normally available to researchers utilizing other study designs. As this case study was designed to describe the context of nurse empathy and patient satisfaction with nursing care in a single institution, it was appropriate that alternative sources of information be included to give contextual meaning to the phenomenon under investigation. Other sources of information are identified as written documents and/or artifacts (Yin, 1984).

Written documents in any hospital are readily available. Sources utilized included the patient's chart, nursing policies and procedures, advertisements, and in-house publications. Nursing diagnoses on nursing care plans were gathered from the patient record and were noted for their emphasis and content. The hospital and department of nursing philosophies were obtained. Policies and procedures for professional nursing advancement were reviewed to ascertain what the hospital administration reinforces and rewards in professional nursing practice. In-house nursing and hospital publications were collected as they became available. Special arrangements were made to review a randomly selected group of unsolicited letters from patients to the hospital.

Other artifacts included recruitment advertisements in
local and national publications. These artifacts were examined for their focus and message for potential employees and consumers. Nonprint sources of information included videotapes of television interviews with facility leaders and national news correspondents. Topics ranged from the nursing shortage to the then-controversial Registered Care Technologist proposal. These videos were tape recorded and their content transcribed.

The researcher was able to attend several units' "Open House" recruitment sessions and a regional recruitment fair. Special attention was paid to the recruitment techniques and literature distributed to potential recruits. Content and mood of photographs and the recruiting display's emphasis were noted.

The researcher maintained a journal to record thoughts and observations during visits to the facility, recruitment fairs, and after interviewing participants. These notes were reviewed and amended as the researcher felt necessary. Body language and affect of study participants were noted in this journal, as was the researcher's impression of the quality of the interview. This journal became a log of impressions and events. These notes were another source of artifactual information.
Data Management

Interviews

Interviews conducted with nurses, patients, and leaders were tape recorded, coded by number, and transcribed by either the researcher or a paid typist. Transcription occurred anywhere from 1 week to 3 months after the interview was conducted. Transcriptions were verified by the researcher by listening to the interview while correcting the transcription. Once transcribed, the interviews were printed allowing adequate space on the transcripts for written codes and comments.

Artifactual Information

Artifactual information was managed in a manner that was congruent with the information's characteristics. Videotaped interviews were tape-recorded and transcribed using the same process as described above. Unsolicited patient letters to the study facility were read aloud, tape-recorded, and transcribed. Nursing department policies and procedures were gathered or photocopied and retained for later analysis. Newspaper and professional journal advertisements were clipped and kept in a file for later analysis. Institutional publications, such as recruitment information, newsletters, and the hospital's magazine were also gathered and kept in a file for later analysis.

The researcher's observations and feelings as arti-
factual information were recorded and retained in a journal-like notebook. This journal was particularly helpful in recalling such events as the regional recruitment fair, the hospital's employee recognition luncheon and recruitment open-houses within the facility.

Survey Instruments

Quantitative instruments were distributed to nurses and patients with the intent of later comparing individual scores with information obtained from interview transcripts. Quantitative instruments were completed by nurses and patients and were coded with the nurse or patient number and retained in a file. In addition to an individual comparison of participant scores with information obtained through interviews, scores of the 12 pairs of nurses and patients were combined. The nurse-patient pairs were coded and the numerical tabulations of survey answers and results were entered into the SPSS-PC program. General frequencies, percentages, and Pearson correlations were obtained on all 28 variables.
CHAPTER III

DATA ANALYSIS AND RESULTS

In this chapter, methods of qualitative and quantitative data analysis will be discussed. Findings will be reported by addressing each research question individually. Information obtained through qualitative and quantitative methods will be presented as it pertains to each research question. Finally, additional findings will be discussed that do not answer a particular research question, but are important and relevant to the study.

Data Analysis

Data analysis for this study was fluid and ongoing. The case study design required continuous analysis and interpretation of anecdotal data to guide further data gathering and facilitate decision making in the data gathering process.

Qualitative Analysis

Data management and data analysis are continuous processes in qualitative research (Patton, 1980). As participants were interviewed, descriptors, categories, and themes on the topics of nurse empathy and patient satisfaction spontaneously emerged. As interviews progressed,
additional topics presented to the researcher by participants were included in the guide and asked of subsequent participants. Adjustments were subsequently made in the interview guide. The development and testing of the interview tool was discussed in a previous section.

Data analysis for qualitative interviews consisted of content analysis, or examining interview transcripts for descriptors, categories, and themes (Miles & Huberman, 1984; Patton, 1980). Patton (1980) further defined content analysis as the process of selecting, simplifying, abstracting, and transforming raw data into some clearly communicable form. As each interview transcript was analyzed, descriptors, themes, categories, and important concepts were noted in the margins. This list of descriptors and categories became a codebook. The next interview transcript was analyzed, noting descriptors, and themes as before. Categories from the second interview were compared with categories from the first interview. The first interview then was reread and recorded for new categories that had developed from the second interview. Each subsequent interview was then compared with the other interviews, noting new categories.

Coding the interviews served to distill massive quantities of interview transcripts into manageable descriptors and categories. Each category was determined to be internally consistent and distinctly different from another
category. Guba (1978) identified the aim of coding as identifying categories that are internally homogeneous and externally heterogeneous. Reviewing and recoding interviews numerous times ensured that categories remained clear and distinct.

Artifactual information and organizational leader interview transcripts were subjected to content analysis as a continuation of the process used to analyze the nurse and patient interview transcripts. The categories obtained from these sources were compared to the nurse and patient sources. The research questions were compared to information emerging from the data as coding proceeded to determine if the questions were being adequately covered through the participants' discussions.

Nurse empathy descriptors were the most numerous and potentially overwhelming. To maintain a record of which participant had mentioned each nurse empathy descriptor, the researcher wrote the descriptor on a 2-inch square self-sticking note and arranged these descriptors in alphabetical order on a large wall. Alphabetical order was used for ease of reference. As transcript analysis continued, the researcher noted the participant number at the bottom of the square note and was able to readily view the entire list of descriptors and also obtain an accurate count of how many participants had used that descriptor. Using self-stick notes allowed the researcher to move de-
scriptors into different groups on the wall easily, and facilitated development of categories and subsequently, various levels of themes.

Single-word descriptors were combined to form larger groups called categories. For example, the single-word descriptors of "friendly," "nice," "warm," and "kind" were combined under the category "friendly." In another example, the descriptors of "follows-up," "anticipates," and "coordinates" were combined in the category "plans" (Appendix E).

Once categories were established, the context in which each category had been discussed was used to create a larger and more inclusive theme. The quantity of information generated in this study resulted in four levels of themes. The first level, a subtheme, was used for the topics of "verbal communication" and "nonverbal communication." These two subthemes were included under the first-order theme of "communication." The second-order theme developed from the grouping of first-order themes that were describing similar phenomena. For example, "facilitating descriptors: the person," was the title for the second-order theme incorporating all descriptors, categories, and first-order themes describing personal characteristics of the nurse as a person that facilitated empathy.

A third-order theme emerged from the clustering of
descriptors, categories, and lower-order themes about positive or negative aspects of a topic. For example, nurses and patients discussed empathic qualities of nurses, qualities of nurses that fostered patient satisfaction, and qualities of nurses that facilitated a nurse-patient relationship. Therefore, the third-level themes of nurse empathy facilitators, patient satisfaction facilitators, and relationship facilitators were created. Other conceptual themes included nurse satisfaction facilitators and positive outcomes of the nurse-patient interaction (Appendix H).

Descriptors and categories that were contradictory or negative also evolved from the data and these were matched with their positive counterparts to give more depth to the category. For example, nurses and patients referred to characteristics of the nurse that would inhibit empathy, patient satisfaction, and relationships. These attributes were placed under third-order themes entitled empathy inhibitors, patient satisfaction inhibitors, relationship inhibitors, and negative outcomes of nurse-patient interactions.

Finally, larger, all-inclusive conceptual themes were compiled to tie together all the descriptors, categories, and themes. These conceptual themes were nurse empathy, patient satisfaction, relationships, outcomes, and supporting information. These conceptual themes were de-
veloped to include all information from this study and are presented.

As content analysis continued, an appended conceptual framework emerged and a conceptual perspective of nurse empathy and patient satisfaction including all the elements of discussion with participants were developed. These two models, the revised conceptual framework and the conceptual perspective, will be discussed in the summary. The revised conceptual framework will be presented in the summary and the conceptual perspective of nurse empathy and patient satisfaction is presented in Appendix F.

Categories and themes were saturated at the completion of interviews, and no significant new information was seen arising from the data. While most participants had similar observations about nurse empathy and patient satisfaction, content analysis revealed the presence of 3 nurses whose responses were different, and, therefore, outlying, from other participant's responses; 2 nurses offered differing perspectives on the phenomena under study, and 1 nurse was perceived a negative case. Outlying responses from these nurses provided the researcher with different perspectives on the phenomena of nurse empathy and patient satisfaction.

Of the 2 nurses who offered different perspectives on nurse empathy, 1 identified herself as not naturally empathic and the other admitted to being rather emotional.
The first nurse had taught herself to be empathic after being raised in a family and environment she called "not touchy." The other nurse, incidentally the nurse who approached the researcher and volunteered to participate in the study, manifested many attributes of the nominated nurses. However, she recognized that she became very emotional at times and that this inhibited her ability to communicate effectively. In her matching patient's interview, the patient also noted this propensity toward intense emotion and corroborated the nurse's impression.

One nurse's responses identified her as being a negative example of nurse empathy, although she was nominated by her nurse manager as being empathic. It was noted that this nurse was fourth on the nurse manager's list of four nurses. This particular nurse stated she demonstrated empathy through attentive listening. However, analysis of her interview transcript revealed that while she listened attentively, she frequently did not understand or believe what patients or families were saying or feeling. Furthermore, she did not indicate a willingness to try and imagine where patients and families might be coming from. She also did not exhibit the trait of learning from past negative experiences. Responses from this nurse are identified in the report of findings below and are usually used to offer an alternative perspective on some themes.
Quantitative Analysis

As mentioned, quantitative data were collected primarily for the purpose of comparing this information to qualitative, interview data. However, the researcher also performed statistical analyses on the quantitative results, with the quantitative data readily available. Statistical data analysis for quantitative surveys consisted of a compilation of percentages, frequencies, and Pearson correlations. Pearson correlations indicate if one phenomenon is positively or negatively related to another. For example, if the age of a nurse positively influenced the nurse's empathy score, there would be a positive correlation. A perfect positive correlation, meaning that an increase in "A" is always related to the same amount of increase in "B", equals 1.00. Conversely, a perfect negative correlation of -1.00 would indicate that an increase in "A" would always result in a proportional decrease in "B."

The small sample size (n = 12 pairs), homogeneity of nurse participants, and diversity of patient participants resulted in no statistically significant findings of theoretical importance. Close review of statistically significant results indicated the results were spurious in nature. For example, Pearson correlations were statistically significant between test scores and other related test scores. All scores within the Patient Satisfaction
Index were significantly correlated with each other, but did not significantly correlate with any other factor. Another example of spurious statistical results was the coincidence that the most educated nurse was paired with the youngest patient, who also happened to have the most hospitalizations. Therefore, statistically significant negative relationships between nurse education and patient age were found, as were positive relationships between nurse education and number of patient hospitalizations.

As intended, quantitative data analysis was most meaningful when analyzed on an individual basis -- in other words, comparing each nurse or patient interview transcript with their test scores. For instance, 1 nurse identified herself as being more analytical in nature and communicating empathy to patients by listening attentively. This nurse's LaMonica Empathy Profile score under "responding verbally" was correspondingly low and her "perceiving feelings and listening" score was correspondingly high. Individual participant analysis correlating quantitative and qualitative results will be discussed in more detail in an ensuing section.

Research Questions

Content analysis of interview transcripts from nurses and patients resulted in a composite picture of an empathic nurse, patient satisfaction, and the relationship between these two phenomena. Attributes were divided into
positive attributes, or facilitators, and negative attributes, or inhibitors. Nurse and patient observations will be addressed individually, followed by a comparison of nurse and patient views.

Quotations from nurses and patients are reported verbatim, with the exception of such phrases as "you know," "ummm," and "you know like." These phrases have been removed to facilitate the flow of quotations. Participants are identified by their code numbers, with "P" indicating a patient quote, and "N" indicating a nurse quote. Names or places identified in the quotations have been altered to protect participant anonymity.

Nurses and patients were remarkably congruent in their descriptions of characteristics of the empathic nurse, the unempathic nurse, and factors influencing patient satisfaction. A conceptual perspective of nurse-patient interaction developed through analysis of transcripts. This conceptual perspective has been divided into sections that will be presented in Appendix F and mentioned at the appropriate point in this chapter. The conceptual perspective will also be presented in its complete form in Appendix F.

Research Question One

Research question one asked,

What is and what conveys nurse empathy from patient and nurse perspectives? How do these perspectives compare?
To completely answer this question, the question will be divided into three smaller subquestions: (a) What is nurse empathy from patient and nurse perspectives? (b) What conveys nurse empathy from patient and nurse perspectives? (c) How do these perspectives compare? Each question will be addressed individually, followed by a presentation of the appropriate portion of the conceptual perspective and a brief summary.

**What is Nurse Empathy?**

**Nurses**

Interviews customarily began by asking the participant what he or she believed empathy was and to describe it in as complete a manner as possible. All 12 nurses were familiar with the term and readily described empathy. Nurses were more likely to speak in abstract terms when defining empathy. Some nurses compared empathy with sympathy, noting similarities and differences between the two concepts from their perspectives.

N002: Empathy is more along the lines of ... not just understanding what a person is going through, but sort of a step beyond, sort of having an emotional connection to what they're going through as well...Empathy is somehow deeper and more emotionally involving for the person who's experiencing it, and in some ways, I think, a certain amount of feeling what the other person feels on some level.

N005: ... meeting the patient where they are, in terms of what they're feeling.... Being able to hear them and understand what they're feeling, even though I may not always be able to feel
Patients

Two patients were not familiar with the term empathy, and the researcher gave these two participants a standard, dictionary definition of the word. Patients tended to speak in simple, more concrete terms when defining empathy.

P001: ... empathy would mean how you would get along with your nurse.... just the association between one and the other.

P002: I think it's sort of being on the same wavelength, understanding somebody else.... Trying to find out where they are, in some sense, ... where they're coming from.

P010: ... understand the feeling and sort of like feel the feelings I guess a little bit. At least know what the other person feels like, I guess.

P011: I think it's how you feel about one another.

Comparison

Nurses and patients varied in their descriptions of empathy primarily in the use of abstract notions. Patient #2 (P002), the most highly educated patient participant, used more abstract terms in her description of empathy. Nurses tended to elaborate on the empathy definition and...
describe empathic attributes in the definition. One nurse summed up the difficulty of describing empathy in words.

N005: ...talking about it in words seems so empty, and it's like, but no, it's something of great substance, but when you're talking about it, (it) sounds kind of drab.

Content analysis of definitions of empathy revealed 28 descriptors that were categorized into five categories. These categories were: (a) intellectual, (b) affective, (c) sensory, (d) imaginary, and (e) interactive.

In the intellectual category, participants used such words and phrases as "understanding feelings," "realize what they're going through," and "mutually shared human experiences." In the affective category, words and phrases describing feelings were most often present. For example, such phrases as "feeling with," "feeling for," "feel about," and "relating to feelings" were predominant.

The third category, identified as sensory, was filled with descriptions of "seeing," "hearing," or "perceiving" what the other was experiencing. The imaginary category was so-named because participants described the use of imagination to put themselves in the other's place, or to imagine how they would feel if they were in the other's place. Finally, the interactive category relied on descriptions that involved a mutual exchange, such as "emotional connection," "same wavelength," and "association between two people."

Patients tended to mention definitions that fell into
the affective category, while the nurse's definitions were more varied. The sensory category, including such descriptors as "seeing," "hearing," and "perceiving" consisted solely of nurse definitions.

In comparison to empathy, the participants' definitions of sympathy revealed that, in their opinion, sympathy was more involved than empathy and did not contain a therapeutic intent. Predominant in these definitions were such phrases as "feel sorry for them," "pity them," and "get it more from strangers and visitors." One patient said sympathy was easier to give saying "you could do it (sympathy) in a minute," while another patient identified sympathy as being "more involved" than empathy.

Generally, nurse and patient definitions of empathy compared with experts' definitions of empathy as outlined in Chapter I. Similarly, the categories developed from participant responses roughly correspond to LaMonica's subscales in the LaMonica Empathy Profile (1986). LaMonica's subscales on the LEP were "nonverbal behavior," "perceiving feelings and listening," "responding verbally," "respect of self and others," and "openness, honesty, and flexibility." LaMonica's categories and the categories developed through content analysis in this study both cover the same broad topic area; however, the concepts included in the five categories are not directly analogous. For example, LaMonica described her "perceiving
feelings and listening" category as follows:

Perceiving feelings and listening demonstrate the participant's ability and willingness to enter another's world of feelings -- to put on another's shoes and understand that world as it is believed to be. Perceiving feelings and listening involve looking at a situation in light of another's goals, strengths, and resources, and feeling that world for the sole purpose of knowing how to accurately anticipate needs. (p. 14)

The above description includes this study's category of "imaginary" component of empathy, but also includes aspects of both the "intellectual" and "affective" categories. While LaMonica's and this study's descriptions of empathy are slightly different, they both adequately describe a complete and complex phenomena.

Generally, nurses were more familiar with the term empathy and the application of the concept, while patients were more simplistic in their descriptions of the concept. Participants occasionally used a definition of sympathy to help them clarify the concept of empathy to the researcher. Nurse and patient participants, while not adding drastically new information to the concept of empathy, offered similar descriptions of empathy.

What Conveys Nurse Empathy from Patient and Nurse Perspectives?

The answer to this question generated the most information and predominated the interviews. For ease of discussion and presentation, facilitating descriptors and categories will be presented first, followed by inhibiting
descriptors and categories. Within these two divisions, each category will be described, including nurse and patient responses.

Facilitators

Content analysis yielded the most information about facilitating nurse empathy descriptors. Nurses and patients discussed at length those descriptors that they associated with an empathic nurse. A total of 116 descriptors was identified from nurse and patient transcripts. These descriptors were compiled into 51 categories and then grouped into 13 first-order themes. Finally, two larger second-order themes were identified and entitled "the person" and "the professional" (See Appendix E).

As participants described empathic nurses and their attributes, it appeared they were using descriptors that could be ascribed to a person or to a professional -- in this case, the nurse professional. Personal descriptors were those that anyone, nurse or nonnurse, could have that would lay the foundation for an empathic relationship. Professional descriptors were those that a nurse would have, namely those qualities traditionally associated with nurses and nurse behavior. These personal and professional descriptors, with some areas of overlap, were visualized as separate and unique. Anyone could exhibit the attributes of "the person" and not be a nurse. He or
she would be an empathic nonnurse. Also, a nurse could exhibit the attributes of "the professional," but not be especially empathic. The combination of these two second-order themes, the nurse as both a person and a professional, were what seemed to differentiate empathic nurses from their less empathic colleagues. It became clear through discussion with participants that the most important precursor for empathic relationships was the personal component.

Certainly it is not inherently possible to truly divide an individual into two halves and identify one half as being "the person" and one half as being "the professional." There is a tremendous amount of interaction and interplay between the two component parts of any persons who also considers themselves professionals. As mentioned, content analysis revealed over 100 descriptors of the empathic nurse. Some subsequent categories of the empathic nurse were identified by the researcher as more personally oriented, others as more professionally oriented. In view of the massive quantities of information presented in the interviews and for ease of discussion, these categories were classified as being a personal or professional characteristic.

1.0 The person. Characteristics of the nurse as a person were discussed by both nurse and patient participants. They described nurses either participating in this
study, or other nurses they had known who they believed epitomized the empathic nurse.

1.1 Demographics. As mentioned, researchers have attempted to identify those demographic characteristics most consistently associated with higher empathy levels. While the researcher did not ask for specific demographic information, these observations were offered in the course of discussion with participants.

1.1.1 Sex. As mentioned, 1 patient had a mother, wife, and daughter who were all nurses. He made this observation about women and empathy.

P017: I think most women can do it (empathy). And I've had three nurses (in the family), and I think women are better at it than men are, you know. (Why?) I just think it's our culture. ... They (men) have to work at it.

Unfortunately, all nurse participants were female and the opportunity to compare responses of participants directly related to perceived differences between male and female nurses did not occur. Because all the nurse participants were female, quantitative data did not assist in the understanding of the influence of sex of empathy scores.

1.1.2 Age. Participants had differing views of the effects of age on the ability to be empathic. While some felt younger people were more empathic, others felt older people were more empathic.

P015: I think it really is inborn, and then you toughen-up, or you find what your defenses are.... I think the other things need to be ... reminded.
You just have to remind people that it's good to be compassionate.

P017: I've got better at it (empathy) as I get older.

Quantitative analysis compared nurse age with her empathy score. There was a statistically significant Pearson correlation (.001 level) of -.7734 between nurse age and the nonverbal behavior component of the LaMonica Empathy Profile. This negative correlation would indicate that for this small sample, as the nurse's age increased, her nonverbal behavior score decreased. LaMonica (1986) indicated that a low score in this area indicates one does not adequately and unambiguously communicate empathy to others in a nonverbal manner. However, as pointed out above, the intent of gathering quantitative data was not to formulate statistical compilations. Also, the small sample size combined with a large number of variables means all results of Pearson correlations are most likely spurious and highly suspect.

1.2 Communication. Descriptors and categories in the first-order theme of "communication" included those items indicating the nurse's ability to communicate verbally, and the nurse's ability to communicate nonverbally, in gathering information about the patient. The first subtheme, verbal communication, was seen as a more active, outgoing form of communication. The second subtheme, nonverbal communication, was seen as a more passive,
receptive, and nonverbal form of communication.

1.2.1 Verbal communication

1.2.1.1 Talking. The category of "talking" included the descriptors of "talking," "communication," and "rapport." The most outstanding component in this category, 20 participants (nurses = 11, patients = 9) mentioned the importance of communication in some verbal form. Patients were more likely to mention the nurse "talking" to them, while nurses used such words as "rapport" to describe this quality. While it was agreed that this quality was very important for a nurse to have, 1 nurse mentioned that an ability in this area might mask inabilities in another.

N017: I've seen people who don't have very good assessment skills as far as nursing goes but maybe they've built up a good rapport and somehow that connection is made (by the patient) that this is a good nurse ... maybe it's more that she's just a good person with lousy assessment skills. But to them, she's a nurse and she is a good person and so they connect a "good nurse."

1.2.1.2 Managing conflict. The category of "managing conflict" also included the descriptor of "mediating." This category described the nurse as being able to bring disparate parties together in the patient's best interest. Nurses identified this quality as important and often discussed this ability when describing their experiences with families or physicians whose actions were at odds with patient's perceived needs. Only 1 patient mentioned that managing conflict was important and this patient was a retired registered nurse.
1.2.1.3 Acknowledges. This category was most often cited by patients. These patients described situations in which they were not acknowledged by others -- family members, physicians, other nurses -- and spoke of how important to them this acknowledgement was. One nurse described how she acknowledged her patients' words.

N002: I hear what's behind the words, and I see what's behind the words, and I say that back to them ... a lot of times people just need to be able to say it and have someone acknowledge that they said it. And that's what makes the difference.

1.2.1.4 Assesses. The category of "assesses" describes how the nurse is able to assess the meaning of an event or illness with the patient. Nurses mentioned this category more often than patients and felt assessing the meaning of an illness very important to help them know and help the patient. Two nurses described assessing, really getting to know the patient, this way.

N009: (I go into the patient's room and) say "well, how are you doing today?" Not "How's your stomach pain" or "how's your head" or "how does this IV feel," but "how are you as a person."

N004: (I think) nursing's there to spend time with the patient, (to) really see how they feel.

1.2.1.5 Informs. "Informing" was the term the researcher gave to the empathic nurse's considerate habit of letting the patient know where she was while working, what she was doing and why she might not be able to be with the patient. Both patients and nurses mentioned this trait.
N001: ... the last thing I say before I leave the room, is 'I'm on the floor, put your light on if you need me. I'll be back in to check on you.' Or, "I'm going to have my lunch now, do you need anything? If you do, put your light on." And I think that they have an understanding there that I'm on the floor. And you lose that with a patient if you're not there when they need you. So when I'm not going to be there because I'm going to be off the floor or I have a meeting, I try to tell people that.

P008: (the nurse) would let me know where she was, or say, hey, today I'm going to be very busy cause it's short-staffed ... I might not be able to come around today, and sit with you like I usually do.

1.2.1.6 Reassures. Reassurance offered by nurses to patients during stressful situations of their hospitalizations was considered important by both nurses and patients. One patient remembered an incident that had happened to him a year before where a nurse was particularly reassuring.

P001: ... they were taking me down (to surgery) ... and my heart was stopping like every 5 or 6 seconds and they were all getting nervous that I should make it down in time to put the pacemaker in ... So while they were getting me ready, and I might be getting a little nervous ... this one nurse came over and she was reciting poetry to me and she was holding my hand. And ... I didn't forget that.... (She was) a little more like a relative than a nurse.

1.2.1.7 Humor. Unexpectedly, both patients and nurses mentioned a good sense of humor and being able to laugh at yourself and life as being an important characteristic for a nurse to have. For 1 patient in particular, a good sense of humor was very important and he mentioned it five times in his interview. As he eloquently stated,
P017: You miss a lot out of life, I think, if you can't laugh at it.

1.2.1.8 Mutual feedback. The category of "mutual feedback" describes mutual communication between nurse and patient that served to facilitate understanding and knowledge of each other. One nurse used the phrase "back and forth" while waving her hand from herself to the researcher to describe this attribute.

N002: ... the fact that there was a back and forth, a mutual, felt thing is what makes it work. I think it is an art, this back and forth between patients and nurses who are genuinely empathic.

Another nurse described mutual feedback as being the facilitating factor in a successful nurse-patient relationship.

N008: ... she let us know how she felt, and we would give her feedback and we would respond to her appropriately, and I think everything worked out really well with her and she let us help her.

1.2.2 Nonverbal communication.

1.2.2.1 Silence. Two nurses mentioned the use of silence as a communication technique. The nurses believed that spending time sitting quietly with the patient, helped the patient to express themselves freely.

1.2.2.2 Uses/reads body language. Also included in this category was the descriptor of "making eye contact." Five nurses felt the use and interpretation of body language was important in the communication of empathy to patients. They cited the conscious use of their own body language and eye contact as a facilitator to patient
disclosure.

N015: (How do you show empathy?) Just by my eyes, like showing concern and true caring from the heart.

One nurse cited her interpretation of a patient's body language as being a critical factor in allowing her to advocate for a patient in an instance where the patient was being pushed toward a premature discharge.

N002: I'm very, very sensitive to what's going on with patients, with their body language. I was watching her and I could really see that she didn't want to talk about this or feel ready to go and ... I was feeling really empathetic toward the situation. I could see that she didn't feel physically well and emotionally ready to leave -- and she was feeling upset ... but she wasn't really saying that. I could see by her body language ... her answers were terse and she wasn't really having a lot of eye contact and I could just tell she was uncomfortable.

This nurse and patient were able to formulate a plan of action and parameters around which the patient would feel comfortable being discharged. The patient stayed in the hospital until both she and the nurse were comfortable with her discharge.

1.2.2.3 Touch (physical). Ten nurses and 8 patients mentioned physical touch as being an attribute of the empathic nurse. One nurse described an instance where she was the family member of a dying patient, and how important a nurse's touch was to her at that moment.

N016: It meant a lot to me to have one of the nurses there put her arm around me ... even though I know she probably has forgotten my name by now, at that moment it was important.
A leukemic patient in remission recalled the first time she experienced the shaking chills ("rigors") sometimes associated with platelet transfusions. Her nurse's presence and touch was very important to her at that time.

PO05: ... the rigors were so bad that she just sat on the bed and just held me while the Demerol was working. I had the rigors for over 20 minutes before the Demerol finally worked.

1.2.2.3 Listen. Within the category of "listen," were also included the descriptors of "hear," "validate," and "not advise." Being a good listener was mentioned by almost all patients and nurses. Patients often recounted instances where they were not "listened to" or "heard," and this was extremely frustrating to them. Nurses realized being a good listener allowed them to know more about the patient and establish a trusting relationship.

N005: ... when you know someone, you get to hear what they're saying a little bit better, and then sometimes you can be their advocate to the rest of the health care system in saying, ... "listen to what they're saying." ... I think a lot of times, more than anything else, they want the nurse just to be there and to listen, to know that they're valid.

One patient, when asked the most important thing nurses should do for patients, said "listen."

P017: ... listen to me. I know. I know a lot about my condition, and I know I've got body signals ... And I know when things are happening to me ... and when things aren't right. And sometimes I tell doctors and nurses that, "this isn't right," or "that isn't right," and they don't believe me ... and I think maybe people could listen a little more and give people more credibility.
1.3 **Comfort with others.** The first-order theme of "comfort with others" was chosen as a contrast to "communication." This theme describes those attributes of the nurse that indicate he or she is comfortable with others. This is demonstrated through such actions as being sensitive and astute and accepting the patient where they are.

1.3.1 **Understand.** "Understand" and "know" were descriptors of this category. Every nurse participant used the word understand or know when describing their ability to be empathic with patients. Eight patients mentioned this quality, as well, and it was apparent that this ability to understand and know the patient was important in providing insightful care and being a patient advocate.

One nurse described her insight into a lifelong resident of a home for the mentally handicapped who also had cerebral palsy, when she determined this individual was not mentally handicapped at all.

N002: ... in our interactions, it was just really clear to me that she was cognitively not impaired at all, and that her emotional responses were completely understandable in the context of her life.

Experience also contributed to knowing and understanding a patient. One patient described the ability her nurse had to understand the patient's reaction to a miscarriage.

P008: ... it's almost like she had experienced or been there, well, not as far as a miscarriage, but she could sort of sympathize with what I went through, or maybe somebody else there went through
the same thing, and she had a chance to sort of understand, so on MY time, by MY being there ... it was almost like she read my mind, read my thoughts.

1.3.2 Astute. Descriptors within this category included "sensitive" and "attend." The three descriptors were combined in this category as they were used in similar context to describe the nurse's ability to pick up subtle cues and interpret their meaning. Eleven nurses and 9 patients mentioned this ability as being important.

N002: ... I'm very, very sensitive to what's going on with patients, with their body language. I hear what's behind the words, and I see what's behind the words.

1.3.3 Open. This category included the descriptors of "open" and "believe." Being open to patient communication and believing what patients said was a descriptor mentioned by 6 nurses and 2 patients. The 2 patients mentioning this descriptor also recounted experiences with nurses who were not open and/or believed the patient.

1.3.4 Space. Allowing for "space" between nurse and patient was a delicate issue mentioned by 3 nurses and 2 patients. Nurses mentioned space in such contexts as "giving the patient some space" to deal with stressful issues. One patient who mentioned "space" was more concerned about the nurse's becoming overinvolved.

P001: ... don't get that close where you get hurt. Just do the best of your ability to make the patient at ease and help them as best you can, but ... it bothers me that if a nurse got close ... close to every person, she'd be wringing her heart out every week. You got to do your job, you can
still be close to them, but you can't get that close.

One patient, with nurse aid experience, understood the need for space between nurses and patients.

PO08: I worked with very nice nurses, but I know some of them can be very impersonal when they want to. They don't get involved, and I can understand why, because you get personally involved, and then you sort of lose perspective of your job 'cause then feelings start getting in the way.

1.3.5 Accepting. Acceptance, or unconditional positive regard, was mentioned by 7 nurses and 6 patients as an attribute of an empathic nurse. As 1 patient put it,

PO05: I feel more comfortable asking (my nurse) a question than I do my own doctor.... Even though she's not a doctor. She's been there. She's got experience. She's (got) knowledge. And there'll be questions that I'll ask her before I'll ask my doctor. She won't think they're ridiculous, where he may.

One patient mentioned how her nurse's acceptance allowed her to freely express her fears and cry, something she does not do often.

PO11: I'm not a crier. And ... the two times I was in the hospital; however she talked to me, she can get me to cry. And, it's good for me. It really is, because ... I keep a lot of my feelings inside, and she has that way about her that she can make you feel that she really cares.

As 1 nurse described acceptance, she recognized that no two patients would experience the same disease in the same way. Accepting them "where they were at" was important.

NO17: But I think that's where empathy comes in, to look at each individual ... especially when each person is so ... different and no two patients are at the same stage at the same time. A lot of them ... are going through the same
thing, it's just that they're each at a different level. So try to look at the level that they're at.

1.4 **Self-knowledge.** The first-order theme of self-knowledge evolved from information representing the nurse's comfort with self and insight into own behavior. As a reflection of this self-knowledge, these nurses had presence, were balanced, and were comfortable with self-disclosure.

1.4.1 **Being there.** The category and descriptor "being there" appeared in virtually every interview in one form or another. The quality of "being there" began to take on an almost mystical quality to nurses and became a major theme throughout all nurse and patient interviews. "Being there" almost became synonymous with empathy. Nurses usually discussed "being there" in more abstract terms, using such descriptors as "energy" and "presence." Patients simply knew that the nurse was there when they needed her, and that was important to them.

N005: Usually, more than anything, it's just my presence there.... But basically, just being there, being present with them through that time, and being reliable in that.

N008: I think that they really know that someone is there for them. And I think that that's a big part of our job, letting people know that we care about them, and being there for them.

P005: (What has gone into having this understanding between you and your nurse?) Just her being there for me. (Being there in what sense?) (pause) Mentally, physically, coming over and hugging me...
One patient with experience in the performing arts was more aware of this quality of presence. In the theater, this quality is also referred to as being "centered" or "grounded."

P015: ... you don't feel they're looking at their watch when they're with you, or that they are distracted. (pause) It's that quality of ... being there ... just allow yourself to be there.... There is a calming influence as a result of someone who is here. They are centered, they are grounded, they are there. You know, for however long they are there with you, that's their purpose. You don't feel they are thinking about the train they have to catch, or the other patient that they have to administer to.

The frequency with which "being there" appeared in interviews prompted the investigator to include more probes in the interview regarding this category. In further investigating the descriptor of "being there," participants were asked "Can you be there without really being there?" In other words, if you were unable to be in the room, would the patient still know you were there for them if they needed you? Nurses and patients agreed this was possible.

N001: I think there's some days I'm so busy ... I spent a lot of time with someone else, and I'll go into the other room and say, "Sorry, I didn't get to see you much today," and they'll say, "That's OK, I knew you were there." So I think ... they feel that they're cared for and someone is going to be there for them.

Participants were also asked if a nurse could be physically present, and yet not be there. Again, participants agreed this was possible, and all felt they would be able to discern if the nurse was there mentally, or preoccupied
with other concerns.

1.4.2 Self-actualized. One nurse mentioned that a self-actualized nurse would be a more empathic nurse. While only 1 nurse mentioned this category, the researcher felt this nurse had made a particularly important observation, and self-actualized was included in the "self-knowledge" theme. As discussed, a strong sense of self is necessary to enable the individual to project his or her imagination into another's experience. The necessity of the nurse being self-actualized in order to effectively utilize empathy in a patient-care situation would probably also be supported by Maslow's (1954) theory of the hierarchy of basic needs, with self-actualization being the highest level of personal achievement.

1.4.3 Intuitive. Two nurses mentioned intuition as being a descriptor of the empathic nurse. They used this term in context with the nurse's ability to intuit what was going on with the patient. Both of these nurses also identified sensitivity (see above, under "comfort with others") as a descriptor, but felt intuition went beyond simple sensitivity. Benner and Tanner (1987) identified the use of intuition in clinical nursing settings, but used intuition to describe an unconscious knowing about a patient care situation. Nurses in this sample used intuition more often to describe their ability to intuitively know another in a way they could not easily describe.
1.4.4 Balanced. Two descriptors, "balanced" and "assured," were included in this category and used to describe persons who know themselves well enough to know how to meet both their own needs and the patient's. The following anecdote is an example of the development of this balance. One nurse described an instance in nursing school where she became so involved with a patient in respiratory distress that she began experiencing respiratory difficulty. She was asked how she handles that situation differently now.

NO17: I was so overstimulated by all the medical things that were going on. I guess until afterwards I really didn't focus on my own needs. But now I look at the patient underlying all those other people in the room and although he or she is getting short of breath, trying to talk them through it. I think sometimes I talk them through it to talk myself through it.

One patient described how her primary nurse was able to balance her perspective and involvement.

PO08: ... But (my nurse) could ... put it in perspective, not the point where she was a busy-body or ... telling me what to do, but she could balance it out ... be a nurse and also be a person ... be a friend. That's what I like, she balanced it out.

1.4.5 Sharing. "Sharing" and "self-disclosure" were descriptors included in this category. Nurses' self-disclosure was mentioned by 5 nurses and 2 patients. One nurse, whose responses to questions were different from other participants, was concerned that self-disclosure was really serving the nurse's interests and not the pa-
tient's. The other nurses and patients differed with this opinion. Nurses felt limited self-disclosure facilitated the nurse-patient bond and formed a basis for future conversations. One patient, newly diagnosed with AIDS, was impressed with the nurse's ability to balance self-disclosure with respect for patient privacy.

P015: It's a really delicate thing. And I was amazed at how well they did it. They never really invaded my personal life, and I really did not invade their's. But we still shared things about how we felt. We shared very personal things.

Young (1988) asserted that clinician self-disclosure is an important component of nurse-patient communication as this sharing establishes a mutual knowing and, therefore, a mutual trusting with the patient. Nurse and patient participants in this study substantiated Young's premise of the importance of self-disclosure to patients.

1.5 Philosophy of life. The nurse's philosophy of life was discussed in many interviews. As will be seen in the next large category entitled "the professional," nurse participants' philosophies of life and their philosophies of nursing were often very similar.

1.5.1 Valuing relationships. Half of the nurse participants mentioned the importance of relationships in their lives. One nurse learned that this valuing of relationships became so important to her that she made a career change.

N002: The reason I moved to (this city) was to go to law school, but I put it off for a while and
worked at (an institution for the disabled). And it was working there that completely changed my mind about my career. That made me realize because of these kinds of relationships with these people that I had never, ever considered nursing before that, and would have thought it was just like too traditionally sex-stereotyped a profession for me. But I discovered about myself this kind of bonding with the clients and made ... a career change.

1.5.2 Positive attitude. Five patients and 3 nurses noted that the empathic nurse had a positive attitude and outlook on life. These nurses were described as optimistic, energizing, and happy. That patients commented on this quality more often than nurses might indicate that a nurse's mood and frame of mind impacts the patient more than nurses may be aware.

1.5.3 Making a difference. Nurses mentioned one of their driving forces was to make a difference or have an impact on people and events. While this was usually mentioned in relationship to nursing care and helping a patient, some nurses would expand this philosophy into making a difference in the world, in general. They saw nursing as the ideal profession to enable them to make a difference in others' lives.

N014: And it's seeing (that) you make a difference in somebody's day, and ... you're the person. When they come in, they look forward to seeing you and sitting down with you, and telling you what's happening and asking your opinion ...

1.6 Hardiness. Hardiness includes the individual's commitment to an idea or goal, enjoying the challenges of life and work situations and adaptability to change
(Pinkelton, 1982). Content analysis revealed the theme of hardiness when participants were speaking of empathic nurses. Hardiness developed as a category because a few nurses mentioned the descriptors of commitment to nursing and their enjoyment of the challenge of nursing. The subject of adaptation to change did not arise in participants' interviews. While contexts used when describing this category were usually speaking to the nursing profession, it was included under the larger category of "the person" because the researcher believed this quality of hardiness was more a personal attribute than a professional one. Vaillot (1966) identified a connection between existentialism and the characteristic of commitment and empathy in nurses. Vaillot said,

To advocate this particular nurse-patient relationship implies a belief that it is possible for two persons to share one another's emotional experiences, to communicate with each other, not only verbally but beyond the conceptual level... It also implies that the nurse is perceptive enough and sensitive enough to empathize with the patient. (p. 500)

1.7 Experience. This first-level theme emerged as various life and personal experiences were recounted by nurses that they believed had developed them into the person, and nurse, that they were at that moment. The descriptors and categories clustered in this theme were believed to be a result of varied life experiences that would allow the nurse as a person to interact with others and perform the nursing role in a special manner.
1.7.1 Learn from experiences. Nurses identified their families of origin as having a great impact on their adult behaviors. Most nurses believed their empathic ability was nurtured in their family of origin.

NO01: Our family is real close, and some people are brought up in a very supportive environment where they had empathy from their parents and from their brothers and sisters... so it's an integral part of themselves. And of course there are people who haven't had that, and it's hard for them to give or to try to understand others. Another nurse, identified as an outlier, mentioned how her family of origin did not model empathy or closeness. She described how she identified this missing ability within herself and decided to learn how to be physically closer and more empathic with others.

NO02: I didn't grow up in a real touchy family, and I've sort of had it as part of my own personal growth to just be more physically close with people.... some people may have grown up in a way that it comes to them a little more naturally and some people may have to put a little more effort into learning it, and not everyone chooses to... a lot of those things that I do to communicate empathy I have learned how to do, but somewhere I wanted to be able to do it.

One nurse commented on how her personal life experiences helped her understand where patients were coming from.

NO05: I do know a lot of what it's like to be around someone who's ill, or someone who's emotionally demanding. I know what it's like to be left alone, and all those things, and I think even though I can't perceive exactly what they're going through, the general feelings that they express sometimes, I've felt them in my own life, and that helps me then to better understand the hurt involved or the pain involved and what they're going through.
The same nurse mentioned how much patients taught nurses, if the nurse was open to the experience.

N001: When people say, why do you do oncology nursing, it's that people are more up-front and more honest and real about what's going on for them and what's important. All of a sudden ... they lose all of that excess baggage and also start dealing with ... the crux of what's going on and what's important to them and you can learn so much from them if you just take the time to allow it to happen.

1.7.2 Recognizes patterns. Benner (1984) indicated that pattern recognition is a tool that advanced practitioners use in everyday practice. Three patients identified an experienced nurse's familiarity with situations and patients as assisting in the nurse's ability to handle new situations. One nurse, a 10-year staff nurse veteran, identified recognizing similarities in situations as a skill she used.

N005: I think we tend to react and we want to take care of things quick, so I think that I would say, ... Give yourself time to stand back and watch, look back at situations, see similarities, and learn from them.

1.7.3 Holistic. Three nurses mentioned a holistic focus to their nursing practice and identified this focus as important to them personally. Holism is included in this second-order theme (the person) because the researcher thinks the nurse's ability to practice holistically depends on her personhood, not her professionalism.

N001: I take care of the whole person. Not just their ... body, or their physical needs, but there's more to it than that, that a lot of ... getting better ... it's the mind with the body ...
there's a lot of emotional care that's passed between patients and nurses that you don't understand. And I told [sic] people that, until you're a patient, until you have a family member who's a patient, you can't appreciate that.

Nurses also identified holistic care as extending beyond the patient and including the patient's family.

N009: You're not just taking care of their medical needs but ... if their family is the problem and they're not dealing with whatever illness the person's here with, you need to try to help them.

1.7.4 Flexible. This category described the nurse's ability to prioritize patient and nurse needs in the continually changing circumstances of floor nursing.

Nurses recognized that flexibility was an ability that came with experience, comfort with themselves, and comfort with others. Patients especially appreciated the nurse's ability to be flexible. They often recounted instances of nurse inflexibility that caused great frustration and stress during their hospitalization. One elderly patient noted the differences between younger and older nurses and used the term "bending rules" to describe flexibility. It was interesting to note that while this patient insisted nurses with more experience were better and more flexible, her 31-year-old primary nurse had only 2 1/2 years of nursing experience. Attributes the patient may have credited to nursing experience, may have actually been due to life experiences, insight, and maturity.

PO02: (More experienced nurses) ...they know where they can bend rules, where it's not so critical, or where it makes a differences, or where it
doesn't make a difference. They just have that experience.... it makes a BIG difference.

1.7.5 Persist. Included in this category were the descriptors of "persistent" and "thorough." Three patients and 2 nurses mentioned persistence and thoroughness as descriptors of the empathic nurse. These terms were usually used in describing an instance where the patient did not want to participate in an activity or learn something necessary to his or her illness, but the nurse gently persisted in the patient's participation. This persistence was seen as evidence that the nurse cared and was not readily willing to "give up" on them.

1.7.6 Patient control. This category included four descriptors: "control," "choice," "pace," and "style." Control and choice were used in the context of allowing the patient to control situations as much as was feasible. Pace, another term for patience, was the term used to describe the nurse taking activities and learning at the patient's pace, rather than her own. This was particularly important to patient participants, all of whom were able to recount instances of nurses "pushing" them into activities that they were physically not prepared for or able to perform. As 1 nurse pointed out, patients know the difference between a pushy approach and a patient-centered approach.

N001: I think that they recognize the difference between someone who is calm and warm and gentle with them, and someone who is, "Come on, hurry up,
get in the chair." ... and they both take the same amount of time to do the same tasks, but it's the way you approach the situation.

The term style was used to describe the nurse's ability to adapt her personal nursing style to meet a patient's need. One nurse was able to identify her difficulty in adapting her style to a patient's in a case where she had difficulty with a particularly passive patient.

N002: ... another nurse who does much better with him has a style about her where she actually treats him a little more like a child, whereas I say, this is an adult and I treat him like an adult.

The researcher visualized the combination of all four descriptors in this category as roughly analogous to a nurse-patient "dance," in which the nurse allowed the patient to "lead."

1.7.7 Plan. The category of planning included the descriptors of "follow-up," "anticipate" and "coordinate." Being able to see beyond the moment and making sure patients received the interventions necessary for their care are common examples in this category. Nurses following up with each other and other health providers, anticipating what the patient might need, and coordinating health care services were activities that nurses at the study facility were expected to perform as part of their everyday duties. However, patients noted that sometimes this did not happen and expressed frustration when communications were not passed on to others. One patient was particularly im-
pressed with his nurse's intervention on his behalf. He mentioned this incident more than once during the interview, indicating that the physicians involved in his case appeared unconcerned with, and did not follow-up on, the possible cause of his troubling dizzy spells.

PO01: I got all these teams of doctors coming in. And ... they (want to) discharge me, a day earlier. I got dizzy again. And all the doctors said, no problem. Not (my nurse)! Then I got dizzy again ... and I was a little anemia [sic] and she thought I would need some blood. She finally figured out, maybe that's what I need. And she told them to hold me another day. And she was right.... They gave me two pints of blood. I was fine.

1.7.8 Redirecting. Only 2 nurses mentioned the descriptor of being able to redirect a patient's focus, but it seemed of such importance it was included as a category. As 1 nurse described a leukemic patient undergoing a bone-marrow transplant and the ensuing weeks of total reverse isolation and severe symptoms associated with this treatment, she recalled how this patient was getting discouraged and giving up, saying he did not know why they (bone marrow transplant patients) were putting themselves through this often life-threatening treatment.

N005: Each day they wake up wondering if they're going to die today. And I can't change that. But what I can do, that makes a difference, is more respecting the reasons they put themselves in that situation -- why they decided to go with a particular treatment. And then, when they lose their perspective on that, perhaps we can help in the analysis when they feeling so rotten, then help them recall why they made that choice.

1.7.9 Individualizes. The word individualize was used
to describe the nurse's ability to see each person as unique.

N009: They know that you're treating them as an individual, not just some patient and they like to think that they're special. They're just not another one of those names up on the (primary nursing) board.... They like to know that you really care about them as an individual.

This term was also used to describe the recognition by nurses that their peers were individuals who practiced nursing in a unique manner. Practicing nursing differently did not mean it was better or worse, simply different.

N004: I suppose everybody has their own ... style. You can take two people, (who) got out of school together from the same school ... you learn the same kind of knowledge type stuff, but, if you compared interactions with patients ... there would be a difference just because of personality-wise differences. I think you bring into it ... your own style and somebody may be more compassionate than someone else, but somebody else may have other traits which help them to care for a patient in a good way. So I think ... you make it (nursing) what you are really like.

1.7.10 Problem-solving. Problem solving was that ability of the nurse to identify an area of concern and persist in finding a solution. Similar in nature to the categories of persistence and follow-up, problem-solving is different in the sense that the nurse required the personal experience and self-confidence to know how to go about problem-solving and reach a solution to the problem.

1.8 Other qualities. Those qualities of a person that did not seem to readily be ascribed to any of the above categories were placed under this general category called
"other qualities." Generally, these were personality traits of a person that participants recognized as having empathic abilities.

1.8.1 Take time/sit down. The descriptors most often cited by nurses and patients as being important to the demonstration of nurse empathy were "time," "sitting down," and "talk." "The nurse took the time to sit down and talk," and "having the time to sit down and talk to the patient" appeared repeatedly in every nurse interview, and in all but 2 patient interviews. These attributes, "time" and "sitting down," were seen as enabling factors that allowed for the demonstration of many of the other descriptors.

Nurses said taking time and sitting down were critical factors in getting to know and becoming familiar with their patients. All nurse participants saw these enablers as being critical to providing the kind of personalized nursing care they expected of themselves. Not having the time to sit down was extremely frustrating for nurses and they sympathized with nurses who did not routinely have time to sit with patients and talk.

N008: I get really frustrated when it's really busy and you can't take time to sit down with patients. I mean that's my big thing, that's more frustrating than anything else. I think that's a big part of our job. Just to sit down and talk to them. I think that's really important and I could never do it (be a nurse) if that's the way it had to be every day.

This nurse's patient sensed when the unit was too busy for
the nurse to spend much time with her. However, this nurse-patient pair had the type of rapport in which much could be said in a short period of time.

PO08: And there were sometimes she was very busy. They was [sic] sort of short staffed and she would come in and sit with me for a few minutes and ask me how it's going, and say, "I know it's not easy, but, you know, you're going to get through it" ... things just like that.

Another patient noted the difference between those members of his renal transplant team who spent time talking with him and those who did not.

P017: ... (my nurse) took a lot of time to explain things to me, and I just think the rest of them ... I mean, I'm supposed to be on this team. I feel like I'm the football on the team.

Patients also recognized that nurses were busy and that there were other patients to administer to. Patients were extremely appreciative of the time their nurses could and did spend with them.

P015: It was truly important to me that they took the time. If I had questions, they always answered them.

One pair of participants, nurse and patient, both commented repeatedly on the importance of sitting down and spending time with one another. These two individuals were a good match for each other, as both had similar priorities and beliefs about what was important in a nurse-patient relationship.

1.8.2 Friendly. Many descriptors were used to describe this category of the nurse as a person. The terms "per-
sonable," "warm," "kind," "likeable," "friendly," and "sociable" were predominant. Having a friendly, outgoing personality and being open to forming relationships was cited as important more often by patients than by nurses. The researcher noted that all but 2 nurse participants could be described as friendly and warm. The remaining 2 nurses were more reserved in their interpersonal communications with the researcher.

1.8.3 Honest. The descriptors "honest" and "genuine" were included in this category. Being genuine and honest with others was mentioned by 5 nurses and 5 patients. All 5 patients recounted experiences where a nurse was not genuine and honest and, thus, were appreciative of those nurses who were.

PO11: I think if they're phoney themselves, they can't see it (sincerity) as much. You know, because they're so used to bluffing or putting on phoney smiles that ... they don't actually see that. But I think if a person is sincere, they can see it (sincerity) in other people.

1.8.4 Involved. Three descriptors were included in this category: "involved," "interested," and "concerned." Eight nurses and 5 patients used the words involved, interested, or concerned to describe an empathic nurse. As mentioned in "balance," a category in the first-order theme of self-knowledge, a delicate balance of involvement is necessary and requires self-knowledge, experience, and maturity to accomplish. One young nurse described how important, and difficult, involvement could be.
I don't think you could really truly be a good nurse if you just come in and do your tasks that need to be done for this patient without ... ever really feeling, or saying, "God, I feel really bad for that person," or "It's such an awful situation," and really kind of thinking about what they're going through. I don't see how you can separate yourself ... it's hard sometimes to not get really involved with people, but even just a little bit, I don't see how you couldn't do it and have some feeling as to what some of these people go through that we see.... sometimes you take it home with you, and you think about it.

1.8.5 **Vivacious**. Only 2 patients mentioned vivaciousness as a nurse trait that they associated with their empathic nurse. Patients used the descriptors of "bubbly" and "energetic." Patients insisted this vivaciousness did not tire them; rather, they said they drew strength from their nurses' energy.

... but there was just something different about (my nurse). Something special ... but some people got that from the beginning. They know how to light up a room, and she's one of those people.

1.8.6 **Gentle**. One nurse used the term gentle when describing an empathic approach to patient care. More than being physically gentle, her use of the term also indicated a gentleness of spirit with the patient.

I think that they recognize the difference between someone who is calm and warm and gentle with them, and someone who is, "come on, hurry up, get in the chair." ... and they both take the same amount of time to do the same tasks, but it's the way you approach the situation.

1.8.7 **Imagination**. Imaging, projection, or the use of imagination to understand a patient was mentioned by all but 2 nurses. Interestingly, patients did not mention the
use of imagination when describing an empathic nurse. Nurses often used phrases like "putting myself in their shoes" or "what would I be feeling in their place?" Two nurses described the use of imagination to aid in empathy.

N004: (How do you empathize?) I think just by trying to put yourself in his shoes for a minute. And step back and look at it.

N005: (speaking of a leukemic patient in remission) ... what would I be doing if I was in her shoes? ... I would be climbing the walls every time of I heard of someone who had relapsed and was back into the hospital, every time I got a little ache or pain, if I noticed a bruise on my leg.

1.8.8 Care. Caring as a descriptor of an empathic nurse was mentioned by 7 nurses and 4 patients. It was surprising that this attribute was not mentioned by all participants, since nursing and caring are often seen as synonymous terms. As Benner and Wrubel (1988) observed, caring must preclude all other activities in nursing. Perhaps one reason caring was not mentioned more often was because all participants believed caring was "sine qua non" for an empathic nurse, and, therefore, did not comment upon the attribute more often.

1.8.9 Diverting. The word diversion was assigned to the ability of some nurses to divert the patient's attention from what was unpleasant and frightening, to something more pleasant. Three patients had stories about a nurse's ability to divert them at a time when they needed this distraction. Two nurses also recounted
instances when they used a form of diversion with patients. It is important to note that this diversion was not planned or done in a way that would prevent the patient from dealing with important issues. Rather, these nurses seemed to have a talent for diverting, cheering, and distracting patients from unpleasant thoughts and procedures. One patient was particularly appreciative of this ability.

P008: ... (my nurse) was just one of those people if you were in a bad rut, she can get you out of it. You stop thinking about yourself, about the pain that you felt; like she just sort of, she helps you get away from it -- and all of a sudden you forget what you're in there (in the hospital) for.

1.8.10 Liking the patient. It was interesting to note that the nurse liking the patient as a person was not mentioned by more participants. While professionally, nurses are taught and expected to care for someone regardless of their personal feelings; personally, they admitted that if they liked their patient, being empathic was much easier. Participants often used the term "click" to describe this instant liking for each other.

P008: ... it's just something we just click with, and she was one of those people ... we clicked. I thought she was very special ... I think about (my nurse) a lot ... I miss her.

1.8.11 "Little things." This descriptor was used by half of the participants to describe that extra little something that the nurse would do for the patient. Patients were very appreciative of the "little things"
nurses would do for them. They frequently used such terms as "went above and beyond the call of duty," "went the extra mile," and "went out of their way." Nurses, too, recognized that most patients appreciated these little extra things.

N004: I think it makes people feel pretty good even though they're feeling miserable -- that little thing just might pick them up a little bit. So I think if you just take the time to help ... you may have a million things to do, and somebody starts to cry, and you're kind of like, "oh, God, not now;" but just sit down with them for a minute, hold their hand, or whatever. And I think those little things, they remember. They make a difference.

N005: just the simple things ... like making the bed a little bit more comfortable to lie in, or helping them get a little bit of food down, or easing the pain with medication.

P008: I had a problem with the food, I just didn't like what they had, and ... she would go downstairs and find out what they had. She would come back up and say, "Hey, this is good, why don't we get this." So she really ... went out of her way.

1.8.12 Checks in. Checking in was the phrase assigned to the nurse's habit of frequently stopping by the patient's room and asking if they needed anything, even if the patient's call light was not on. Although similar to "informing" described above in the communication first-order theme, checking in was different from informing in that the nurses did not have anything specific to tell the patient. The nurses simply checked in as often as they passed the room and had a minute, to see how the patient was doing. Five patients noted this as being different
about the nurses who were identified as being empathic, and they appreciated knowing that someone was watching out for them and interested in their well-being. Two nurses identified this as a behavior that they thought demonstrated their empathy toward patients.

P009: (my nurse) always said to me, "Is there anything I can do for you, anything you need?" ... she was always comin' and checked me.... I think she's very observant. I think she watches everything. Even if she's walking by to take care of somebody, she looks in and sees if everything's alright. That makes me feel good.

2.0 The professional. Professional qualities of the nurse were contrasted with personal qualities of the nurse. Professional qualities were those more associated with the profession of nursing, and could be exhibited by a nurse without the qualities of "the person" as described in the previous section. There were more descriptors and categories that fell into the second-order theme of "the person" than fell into the second-order theme of "the professional." Participants repeatedly made the point that the foundation for an empathic nurse was laid with the person, rather than the professional.

2.1 Demographics. Nursing demographics, different from personal demographics, were such things as amount of nursing experience and nursing specialty. Interestingly, participants differed on their opinions markedly in answer to the question, who was more empathic -- the inexperienced or the experienced nurse?
2.1.1 Nursing experience. Two patients and 2 nurses saw younger, less experienced nurses as more empathic. They described these nurses as getting overinvolved or enmeshed, hurt, and burned-out at a young age if they did not learn how to balance their involvement with patients. Patient #17 (P017), with three nurses in his immediate family, made this observation.

P017: I think the older they get, the more hardened toward people's misery they get. They have to 'cause it's a self-defense mechanism. I think these kids, that are up on the floor. I just think they are more sensitive to people's feelings. I think older nurses build shells to protect themselves. You just can't watch people die and be in misery day after day. I think the younger they are, the closer to getting out of school they are, they just haven't formed that shell. I think it takes years to form that shell.

A nurse with 3.5 years of nursing experience made this observation about nursing experience and empathy and noted a trait the researcher called "perpetual newness." This perpetual newness was the nurse's ability to see every patient care situation as new to the patient and family, and plan her care and actions accordingly.

N010: I think you start out more empathetic, and get less. (Why?) I think in the beginning everything just as a student nurse or a new grad. Everything is just so, so big. (Big in what sense?) Big, a big deal.... And then when you've seen it a million times. Millions of people have gone through it, they'll go through it. They'll be fine. It's easy to lose that sense of newness and ... sometimes it's easy just to forget that this is the first time this patient is going through it. Try not to lose it (empathy). Try to think, see ... where each patient is coming from at their specific time even if you've been through it a million times with many other patients. Every
situation is different, is new to each new person who experiences it.

Other participants believed the nurse developed more empathy with more experience. Three nurses and 3 patients believed experience made the nurse more empathic.

NO05: ... (empathy) is an art, that it is something that needs to be developed with time. Some people have the gift of it, but I think for most of us, it comes with experience. But it's an art that behooves to you work on a lot, because it is such an important part of what we do.

Another nurse, with 1.5 years of nursing experience, explained the development of empathy with more experience as having to do with becoming accustomed to the "tasky" things and inflexibility that preoccupy the beginning nurse. She believed once these tasks were automatic, the nurse could focus on development of empathy and relationships and be more flexible in his or her practice.

NO14: ... when you're new it's 4 o'clock, you have to take your vital signs, you have to get your pills out -- and you have to do it then, because you have to have that information. Where now, you realize, if you go in and someone's in a crisis, you can spend that time and it's not important to get ... that information at that time... But when you're new, you have to have a system and you have to go by it.... (Empathy) is something that ... starts to come as you've been practicing and you're into doing the tasks and feeling good that you've completed the tasks ... and everyone's safe and alive at the end of the day and I did my job. But then, the more you get into it, your job is something different. You feel, "Is that all I've done, is giving meds and done this?" -- where you come to a point where that's not enough in your job. And it's the contact that you have with patients and ... you realize the feedback that you get from that -- it's more of a feeling, it's not something that you can describe.
One nurse believed the amount of nursing experience made no difference in the development of empathy. She believed it depended on the individual person and their propensity to develop, or not develop, empathy. All participants with an opinion on this issue felt strongly about their views and could substantiate their opinions with accounts of experiences with nurses of varying experiential backgrounds. Statistical analysis of nurses' years of experience correlated with empathy measures were, as expected, not significant. The question of the effect of nursing experience on empathy development remains unanswered.

2.1.2 Nursing specialty. Two nurses mentioned development of empathy was facilitated by working with oncology patients. They cited the reason for this as oncology patients are usually hospitalized frequently over the course of their disease and the nurse becomes very familiar with the patient and family. No other nursing specialty was mentioned as facilitating the development of a nurse's empathic abilities.

2.2 Communication. Communication skills of the professional nurse included those qualities that were taught in school and those that were developed with time. While these attributes might also be attributed as more a personal, rather than a professional, trait, the researcher chose to include these attributes in this category as these communication skills are commonly thought of as
necessary for a professional nurse.

2.2.1 **Teach.** The first category, mentioned by 9 patients and 8 nurses, included the descriptors "teach," "explain," and "prepare." Patients saw the hospital as a foreign environment and relied on nurses to teach, explain, and prepare them for whatever lay ahead.

2.2.2 **Translate.** The second category, related to the first, was "translate." As a foreign environment and culture, the hospital has its own language. Patients relied on nurses to translate "hospital-ese" into language that was comprehensible.

2.2.3 **Subtle.** Another category included in this theme was "tact." This attribute was noted by 6 nurses and 1 patient. Being able to communicate in hostile situations with emotional family members or other members of the health care team was a trait many nurses admired. In an ideal description of this attribute, 1 nurse described how her role model, also a participant in this study, handled a situation with a physician with tact. It is interesting to note in this case that Nurse #17 (N017) had more nursing experience than her role model.

*N017: Just the other day she (role model) had a difficult patient who had been here for a long time and the doctor came in and said, "remove the hand mitts.... We can do this, this, and this." And she said, "No, I don't think we can." Reluctantly she removed the hand mitts. Even though she didn't feel it was in the patient's best interest ... she did do it and he ended up pulling out his catheter and his IV. It was kind of an invasive situation, but she presented that
to the doctor, instead of saying, "I told you so," she said, "Well, this is what he did, do we have to put the IV back in? Or, can I put the mitts back on him now?" ... it would have been very easy for her to just say, "I told you we shouldn't have taken them off, and even though I watched him closely, this happened." I think a lot of other people would have handled that very common situation ... in a much more difficult way. But instead she made it very easy for herself and ... the doctor.

2.2.4 Team communication. The final category in this first-order theme of professional communication was team communication. Five nurses and 2 patients noted this as a way of demonstrating empathy because the nurse was taking steps to make sure patient needs were being met even though she was not there personally to see them carried out. In another manner, team communication also set a tone or atmosphere for the unit.

N014: ... you can just get a feeling for a hospital or for a floor, patients even listen to the dialogue in the hallway. And they (patients) say, "Everyone here gets along so well! ... friendly in the hall, helping each other. In other hospitals, they fight and you hear them yelling, ... they're angry and they're talking about this one, talking about that one," and I've had patients say that ... it's just a nice atmosphere.

2.3 Philosophy of nursing. The nurse's philosophy of nursing emerged from content analysis in a haphazard manner. While some participants did not discuss this area at all, others spent a great deal of time addressing the issue of what motivates nurses. In most cases, as mentioned, a nurse's philosophy of life and philosophy of nursing were remarkably congruent.
2.3.1 Loves nursing. The first category noted in this group included the descriptors "loves nursing," "happy," and "job fit." Participants noted that the empathic nurse did obviously "love nursing" and was content with his or her career choice. While only 3 nurses and 2 patients mentioned this attribute, it took on special significance when discussions turned to nurses who did not like nursing. Negative descriptors will be discussed later in this chapter.

2.3.2 Giving good care. The second nursing philosophy category of the empathic nurse was getting satisfaction out of "giving good care." Similar to "making a difference," nurses saw this as a different attribute, focusing on nursing as a helping profession. While nurses saw this as a mission of sorts, 1 patient observed that nurses "need to get their goodies (rewards) out of service." She also noted that if one did not feel rewarded in doing what she termed "service" for others, one would not feel fulfilled and wouldn't be a nurse, or be a nurse for long.

2.3.3 Realistic. "Realistic" was a descriptor mentioned by only 1 nurse. However, the impact of the 10-year veteran's statement made an impression on the researcher. Having an ability to realistically see patient care and nursing situations and set short-term goals was a sustaining philosophy and force in her oncology nursing practice. Without this philosophy, she doubted she would
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have been able to remain an oncology nurse.

N005: Just look at today, look at the moment, and what we can do to make this moment better. Even though I can't change what the overall is going to be. That can make a difference, being there for the moment. You know, if you looked at the overall picture; and I think sometimes it happens in nursing, you start getting burned out and saying, "it doesn't matter cause in the end they're going to die anyway." And I think at that point then you need to step back and say, "you shouldn't go into that room because that patient picks up on it." But I think if you can be there and help them focus on the day-to-day moments, and making this moment the best of all, that can help.

The remaining nursing philosophy categories reflected the professional component of the nurse's personal philosophies, as have been previously outlined. They included professional foci to valuing relationships, having a holistic focus to their nursing care, and being able to make a difference and have an impact on another's life. One nurse articulated the importance of relationships in her life and in nursing.

N002: When I distill out what's really special or what's really different about what I do for people that makes me love nursing, it's usually got to do with the kind of relationship that I've developed with people. ... And to me that's sort of the essence of what I do as a nurse that really matters.

2.4 Experience. Nursing experience afforded the nurse the opportunity to develop characteristics participants recognized as "confidence," "knowledgeable," and "organized." While personal experiences developed the individual, these professional experiences developed the nurse's ability to practice nursing in a more empathic manner.
2.4.1 **Confidence.** Five nurses and 2 patients noted the empathic nurse had an aura of confidence and they trusted her completely. One patient said she could sleep soundly at night only if her primary or associate nurse was on duty.

P005: (Nurse A or Nurse B), if either one of them would walk into the room, I could be awake, look up and see that it was them, and I'd go back to sleep. I would not worry.

2.4.2 **Knowledgeable.** The second category, having the requisite knowledge to practice nursing, was mentioned by half of both nurses and patients. Some patients recounted instances where they believed their nurses were not knowledgeable or qualified to care for them and contrasted those instances with their participating nurse's knowledgeable care. Nurses believed patients expected nurses to be knowledgeable and accurate and they agreed with this expressed patient expectation.

2.4.3 **Organized.** The third category, that of being organized, was a surprise to the researcher. Three nurses and 2 patients mentioned organization as facilitating a nurse's empathy. One nurse feared her very organized approach to patients would put them off. Another nurse, who had set a personal goal to be more organized, said:

NO10: I think the more organized you are, the more time you have to be empathetic; because the more organized you are, the more time you have to be in a patient's room.

2.5 **Other qualities.** Other professional qualities
that were perceived by participants as being descriptive of an empathic nurse were common nursing functions. Most often mentioned was the word and category "helping."

2.5.1 Helping. Nursing is a helping profession, and it was not surprising that 10 nurses and 8 patients noted "helping," "supporting," or "facilitating" as a characteristic of a professional nurse.

2.5.2 Calm. The second most often noted category in this theme was "calm." Eight nurses and 7 patients identified the nurse's ability to remain calm in a stressful situation or crisis as being important. As 1 patient noted, "I'd get nervous if I saw the nurse running around in a panic." Patients and families take their cues for appropriate reactions to unfamiliar hospital situations from the nurse's behavior. In the quote below, 1 patient recounted how a nurse's behavior calmed her during a frightening situation.

P005: I started to get a chill. And started to shake. I started to get nervous. And (my nurse) is just looking at me and saying "What's the matter?" I said, "I think I'm getting nervous ..." and she just looked at me and could start to see that I was trembling and the next minute I'm into full rigors (shaking chills) ... I didn't know what was happening. My husband come over and tried to stop my hand ... from shaking, and HE was shaking.... I was shaking so bad, he was shaking through me. And he even comments on to this day, if it wasn't for (my nurse), he would've freaked out. (She) just looked and said, "Don't get nervous, this is normal, and I'll be right back." She did not panic. The next minute, she's walking in the room with the doctor and he's giving me a shot of Demerol. But it was through her expression and her professionalism, that I didn't know what was going
on. But it was because of (my nurse), the way she acted, very professionalism [sic] and she didn't get nervous. So when (my husband) saw that (my nurse) wasn't getting nervous, he figured it was OK. It wasn't something to worry about. Cause she wasn't getting panic-stricken.

Another patient connected the nurse attributes of calmness and being there or presence.

PO15: There is a calming influence as a result of someone who is here. They are centered, they are grounded, they are there.

2.5.3 Focused. The third most frequently mentioned category in this theme was the nurse's ability to be "focused" and "objective." These two words were combined to create a category that implied the nurse was able to focus on the patient's needs and not her own and that the nurse had the ability to step back and be objective about patient care situations. Content analysis also revealed opposing information about this category and described nurses who became involved with patients and families to meet the nurse's needs. This overinvolvement was termed enmeshment, and will be discussed later in this chapter under the section entitled "inhibitors." As for being focused, 1 nurse said, "What our needs are, maybe aren't always what their needs are." Another nurse quote illustrates the objective component of this category.

N005: Give yourself time to stand back and watch, look back at situations and learn from them.

2.5.4 Advocating. "Advocating" for patient needs in the health care system was an empathy attribute to 8
nurses and 4 patients. While nurses used the word "advocate" to describe their actions, patients often described situations where the nurse had "gone to bat" for them or had "made things right." The following nurse quotes illustrate this attribute.

NO14: ...(during a code) we always forget (about the patient) because we want to get through the crisis. And we always forget that's a person in there and you really have to advocate for them.

NO02: (a patient was being pushed to be discharged by the MDs) I said to her, "Do you feel like we're throwing you out of the hospital?" And she said, "Yes" and we had this conversation about that and how she doesn't feel ready to go yet; and we sort of formed this alliance around the fact that she didn't feel ready for discharge and I felt ... that I was going to help her to stick to her guns in that way.

NO05: ... when you know someone, you get to hear what they're saying a little bit better, and then sometimes you can be their advocate to the rest of the health care system in saying, you know, "listen to what they're saying."

NO08: I think that it's a big part of our nursing care -- to let patients know that we really care about them and we're fighting for them and we're in their corner.

2.5.5 Comfort. Being able to offer "comfort" to the patient and family was considered an empathy attribute by 7 nurses and 4 patients. This is not an unusual descriptor as nurses are usually expected to comfort patients and families during their hospitalizations.

2.5.6 Professional. A nurse's ability to be "professional" was an attribute mentioned by 4 nurses and 4 patients. Under this category, the nurse keeping a pro-
fessional face on to mask her own feelings was mentioned, as was taking good care of people the nurse might not personally like. A leukemic patient felt it was important for her nurse to hide emotions when the researcher asked this patient if her nurse might become upset if she, the patient, relapsed.

P005: No, she would have to be strong for me, she could not show me (emotions), because I can react to her, she can't react to me.

2.5.7 Consistent. Being "consistent" and "reliable" was an equally important nurse attribute to 6 nurses and 2 patients. Nurses may have mentioned this more often than patients because patients may have an expectation that all nurses are consistent and reliable. The 2 patients who mentioned this attribute had experiences with nurses who were not consistent or reliable, thus rendering them more sensitive to this nurse quality. One patient was particularly impressed that her nurse was where they agreed to meet after her emergency surgery for a large obstructive malignancy.

P014: They came and got me (for surgery). And "Ann" was right there, she came all the way to the desk with me. And I said, "'Ann,' I'll see you later." She said, "All right." I said, "Wait for me at the desk." She said, "I will." And when I came up, I remember "Ann" being at the desk.

P008: (The nurse) would say, if you need anything, ring the buzzer -- but she wouldn't forget to come back.

2.5.8 Respect. Treating the patient with "respect," "dignity," and "consideration" were descriptors mentioned
by 3 nurses and 3 patients. Patients who mentioned these attributes could usually relate instances where they felt they were not treated with respect by nurses.

2.5.9 Acting on information. Three nurses and 2 patients spoke of the importance of the nurse taking action on information given to her by the patient or family. Likewise, patients recounted instances where information given to a nurse was not acted on to their dismay or discomfort.

2.5.10 Prompt. Three patients and 2 nurses recognized that nurse promptness was important to patients. Patients recalled instances where medications were late or delayed, or their light was not answered for extended periods of time.

2.5.11 Safe. Interestingly, 5 nurses responded to the question "What do you think is important to patients?" with the response "safety." Patients did not identify the need for safety as an empathic attribute. Five nurses believed the patient, first and foremost, wanted to feel safe and that it was the nurse's job to ensure that safety.

Summation of nurse empathy facilitators. In summary, nurses and patients were remarkably congruent in their descriptors of what attributes of an empathic nurse were. During the interview phase of this study, the researcher heard the same descriptors repeatedly from both nurse and
patient participants. Descriptions of the attributes tended to be more abstract from the nurse participants, while patient participants often used simpler, more concrete words to describe similar attributes. Anecdotes from both nurses and patients assisted in connecting descriptors between nurses and patients as what a nurse might term "advocacy" and a patient might call "doing right by me."

The only category where nurses and patients differed widely and disagreed was with the issue of empathy increasing or decreasing with age or nursing experience. While more nurses tended to believe empathy developed with more age and experience, more patients believed younger, less experienced nurses were more empathic, but usually termed this as being "sensitive." Both groups had compelling arguments and anecdotes supporting their views.

Content analysis of interviews provided not only positive descriptions of nurse empathy, but contrasting negative descriptions, as well. In the next section, Nurse Empathy Inhibitors will be examined.

Inhibitors

Nurse empathy inhibitors emerged from content analysis as descriptors of a nurse not demonstrating the quality of empathy. Participants often volunteered information about negative cases to help them better explain what was good about a particular nurse or situation. As content analysis
continued, these inhibitors began to appear as mirror images of what participants were describing as facilitators. A separate third-order theme, nurse empathy inhibitors, was formed and again divided into two large second-order themes, "the person" and "the professional."

1.0 The person. Negative descriptors identified by participants as typifying the unempathic nurse as a person were divided into four first-order themes. These themes were "communication," "disengaged," "enmeshed," and "qualities." The first and last themes are analogous to themes by the same name in the section above describing facilitating categories and descriptors. However, the second and third themes, "disengaged" and "enmeshed," were distinct to inhibiting attributes.

When elaborating on negative nurse cases, participants described nurses who had difficulty with relationships. This difficulty was characterized as either an inability to form or maintain relationships or a problem with over-involvement with others. The researcher used the words "disengaged" and "enmeshed," respectively, to describe these nurse characteristics. These concepts will be explored and discussed in more detail in Chapter IV, but are outlined here as nurse empathy inhibitors.

1.1 Communication. Four general categories were grouped in this theme: "not hearing," "not talking," "not astute," and "no humor."
1.1.1 **Not hearing.** Participants described unempathic nurses as not hearing or not listening to what patients said. This inability to hear or listen was attributed to other descriptors that are listed below. Five nurses and 7 patients recounted examples of instances where they were not listened to. One nurse offered an explanation as to how this was possible.

N001: ... you can be in the room with a patient checking a blood pressure, and (be) thinking about the IV that you have going in the next room, or thinking about the dinner you had last night with your boyfriend. You can be in the room, you can hear what they're saying but not process it and really -- respond.

1.1.2 **Not talking.** Another attribute was described as "not talking." While empathic nurses described the use of silence as a communication aid, unempathic nurses did not talk to patients or others even when it would seem appropriate. Four nurses and 1 patient said that an inability to communicate or unwillingness to talk were inhibitors of nurse empathy. In another manner, not talking was seen as contributing to disengagement. One patient described her daughter, a nurse, who had become "burned-out with patients" and now worked in the operating room of a small hospital. This patient described her daughter as a person who "holds everything inside. She doesn't talk it out." The patient connected her daughter's inability to share and talk, with her eventual burn-out.

1.1.3 **Not astute.** A nurse participant who was identi-
fied as an outlier gave the researcher insight into the descriptors "not astute" and "not understanding." This nurse said she communicated empathy through acting like she was listening attentively, because she perceived that people needed to talk. She did not always "hear" what was said, understand where the patient might be coming from, or follow-up with patients and families for more information. In describing her interactions with a terminally ill patient, she asked the physician, not the patient or the patient's family, what the patient's understanding of her prognosis was.

N016: I had asked the fellow if she had an understanding (of her prognosis) 'cause I was getting mixed messages from her ... I thought that it had been clearer during another conversation that she knew what was probably ahead and -- but I asked the fellow a couple of times and he said, "No, it's clear with her as far as what the prognosis is."

In this same case, the adult children of the woman had an extremely difficult time handling her death. One son became angry after his mother's death. The nurse explained her reaction to this instance.

N016: It (his reaction) just wasn't rational, it wasn't realistic. Sometimes you pretend you're empathic when you aren't ... because you don't agree with everyone. I couldn't begin to really understand where he was coming from, but I had to pretend that I understood ... and a lot of times when patients give opinions about things, sometimes I don't think they're valid.

1.1.4 No humor. The researcher was surprised that 2 patients mentioned "no humor" as a description of an un-
empathic nurse. These 2 patients had a wry sense of humor and mentioned that some nurses did not quite know how to respond to their wit. These nurses were also described as being too serious and uninvolved. One patient observed, "You miss a lot out of life if you can't laugh at it."

1.2 Disengaged. The disengaged nurse was described as one unable to establish relationships with others, for a variety of reasons. Nurse and patient descriptions of this nurse are described below.

1.2.1 Distant. Eleven nurses and 7 patients used descriptors of "distant," "cold," "isolated," "impersonal," or "uninvolved" to describe this nurse. Participants hypothesized the reasons for nurse uninvolvment were nurse self-preservation. One patient with nurse aid experience described nurses she had worked with.

PO08: I worked with very nice nurses, but I know some of them can be very impersonal when they want to. They don't get involved and I can understand why because you get personally involved, and then you sort of lose perspective of your job cause then feelings start getting in the way.

Nurse participants described more complex reasons for an inability to get involved. Some mentioned family background, getting hurt by getting too close in the past, or not seeing the need for involvement as reasons for distance.

NO17: Maybe the nurse doesn't feel it's very important or the nurse doesn't recognize the need -- maybe she's never seen the need? Or maybe she doesn't see any need in it for herself, so therefore she doesn't perceive it in someone else.
1.2.2 No time/not sitting down. Another category identifying an attribute of the disengaged nurse was "not sitting down/no time." As mentioned previously, virtually all participants identified sitting down and taking time to talk to patients as being nurse empathy facilitators. Not surprisingly, 8 nurses and 4 patients identified the inverse, "not taking time and not sitting down," as being inhibitors. Nurse participants, in describing colleagues who they believed were disengaged, said that often these nurses would have time to sit with the patient, but chose to spend that time in staff break rooms or on the phone dealing with personal matters. Patient participants saw these nurses as unwilling to spend time with patients and uncomfortable with patients. They also said that if the disengaged nurse did spend any time with them, the end result would not be satisfying as this nurse would remain uncomfortable, distant, and uncommunicative.

1.2.3 Insecure. The category "insecure" evolved from the descriptors of "insecure" and "fearful." These were cited as reasons for disengagement by 2 nurses, but were deemed an important insight into this category. One nurse had this to say about the fearful nurse.

NO01: They (the nurses) have their own insecurities about giving that much, and feeling that they're giving that much of themselves, and not being able to cope themselves when someone's ill.

1.3 Enmeshed. In contrast to the disengaged nurse, the enmeshed nurse was characterized by participants as being
a younger nurse who would use patient relationships to meet her own personal needs. In this category, nurses described colleagues who were dependent upon patient relationships to meet self-esteem needs. Codependence of the nurse on the patient is a definite possibility in these cases. Interestingly, patients were not necessarily flattered or pleased with nurses who might become over-involved with them in this manner. One patient, diagnosed with multiple myeloma, mentioned four times in his interview that he was concerned about the nurses getting too close.

PO01: It bothers me that if a nurse got close ... close to every person, she'd be wringing her heart out every week. You got to do your job, you can still be close to them, but you can't get that close.

This was his response when asked if he would worry if he saw the nurse getting too close.

PO01: Not really. I figure it's her problem, if that's what she wants. I wouldn't say to her, "Hey, back off, you're going to get smushed if you get involved with me."

1.4 Other qualities. General qualities of the unempathic nurse included those descriptors and categories that did not fit readily into any of the above three themes. They are described below, beginning with the more frequently mentioned category and ending with the least mentioned category.

1.4.1 Preoccupied. "Preoccupied" was the term and category assigned to participants' descriptions of nurses
who were not focused on the patient's needs and who had priorities that differed from the patient's. Five nurses and 3 patients mentioned this characteristic in their interviews. Nurses were more articulate about this phenomenon and could describe peers whom they saw as preoccupied and unfocused on patient needs.

N015: There are people (nurses) who don't get as readily involved. I think they just kind of put in their time here and have their priorities elsewhere.

It was hypothesized by nurse participants that the preoccupied nurses had needs of their own that required being met before they could begin to meet patient's needs. These needs might result in preoccupation manifesting itself as a distant, uninvolved approach to patients. Conversely, it could also result in a smothering approach to meet the nurse's needs for feelings of self-worth.

One patient described an incident with a physician that beautifully describes this quality of not being focused on the patient's needs. While this study is not about patient-physician interactions, this well-articulated quote is included here because of its descriptive value. This patient had informed the physician prior to performing this procedure that he did not like "needles" and that he would meditate through this procedure to help him cope. He did not feel the physician heard him or had his best interests at heart.
PO15: (There was a) doctor, right when I admitted who was unsuccessful (placing an arterial line after three attempts) ... It went on, and on, and on. And another doctor suggested that she take a break, but she wouldn't... And it was very clear to me that it stopped being MY movie and it became HER movie. It was about her determination to do this THING. And it became a THING ... That's when I became somewhat scared and upset. Because I had no confidence in her. She was so determined to prove something, that I didn't matter very much anymore, and that is the worse thing you can do to a person. You don't matter. You know, my procedure matters. My success matters.

1.4.2 Inflexible. Descriptors of "inflexible," "rigid," "control," "not pacing," and "not adapting" were grouped together to describe the behavior of some nurses that was very upsetting to patients in the category "inflexible." Three nurses and 4 patients related rigidity, inflexibility, and issues of control or power as traits of unempathic nurses. Identified as personality traits, these habits were reflected in the nurse's work. This following quote typifies nurse inflexibility. The patient, who had considerable difficulty sleeping, did not appreciate being awakened at night.

PO02: I happened to be soundly asleep that night, so she came and woke me up at 10 o'clock 'cause there was some medication I was supposed to take at 10. And then she woke me up out of a sound sleep at 12 o'clock because there was another medication I had to take at 12. And then, I said, to her, "While I'm up, why don't you do my vital signs" and she said, "Oh, no, I don't do those until 4." (laugh) And I said, "I don't want you waking me up anymore, that's just dumb."

Other examples given included such occurrences as the nurse insisting the patient have treatments or dressing
changes when visitors were present or waking patients up every hour all night for vital signs. As related by a young cancer patient, the following quote demonstrates how nurses on an unfamiliar unit were inflexible about the length of time a unit of blood was transfused.

P016: I was on another unit where they didn't know me. I was getting a blood transfusion; I was waiting all afternoon for it and the blood came up at 11:00 at night. My blood has always run over an hour and a half, each unit. I said, "You know I was just going to bed" and they said, "Well, we have some work to do" and I'm like - "NOW?" And they said, "Yeah and we're going to have to wake you up every hour for temperatures and blood pressures, and each unit is 3 to 4 hours." So that means that I'm going to be waking up every hour on the hour all night long! And these nurses didn't have an easy time understanding how I felt about it. They kept saying "Don't get hostile. You know we have to do this."

Other examples given by patients were cases in which the patient did not feel physically able to perform a task the nurse required of them, such as walking to the bathroom unaided or getting from bed to chair soon after surgery. These patients recalled these instances clearly and often referred to these nurses as "pushy." When the nurse forced one patient to get out of bed before she felt she could stand unaided, she said to the nurse, "You can push. But don't shove."

1.4.3 Patronizing. "Patronizing" was the third most frequently mentioned category in this theme. Four nurses and 3 patients offered descriptions of this characteristic and described instances where they had experienced or
observed patronizing, rough, or rude behavior from a nurse. These occurrences were remembered in great detail by participants, whether the incident had occurred recently or decades ago. One nurse vividly recalled an incident from a brief hospitalization 4 years earlier for a tonsillectomy.

NO01: I kept vomiting and they thought it was (caused by) the Demerol, and she (the nurse) forced me to have this popsicle. And she said, "Here have this popsicle, you'll feel better," and I said, "No, I don't want it, and she said, "Listen, honey." She was really patronizing to me and I didn't like it. So she said "You should do this, you'll feel better" and I didn't want to. And I did it, and I threw up again, and she said, "Maybe it was the Demerol," and I said, "NO, the popsicle made me sick." And it was like she didn't listen to me.

A patient participant recalled an incident 36 years earlier with a nurse who made the labor and delivery of her first child a memorable, and upsetting, experience.

P009: When I had my first baby, I was only 18 years old. I was a kid and I was in labor at the (other) Hospital. This nurse in the maternity room ... It was terrible. She was screaming at me, "You went to bed with your husband, this is what you get."

1.4.4 Anxious. Six participants, 3 nurses and 3 patients, identified the qualities of "anxious" and "not calm" as descriptors of a nurse who was not empathic. As 1 patient put it, "I would get nervous if I saw the nurse in a panic." The 1 volunteer (not nominated) nurse, identified as an outlier, offered this insight into her own behavior when she was anxious.
Sometimes I feel like I don't make people feel comfortable around me. Usually that's when I'm very upset about something.

Her patient recalled an incident that corroborated this nurse's suspicions.

I remember (my nurse) was upset for me, that my fever was so high. It made me want to calm her down.

1.4.5 Not caring. "Not caring," "not considerate," "not compassionate," and "not helping" were other descriptors 4 patients and 1 nurse described nurses in this category. This descriptor was usually used in a broad sense. More patients used this descriptor than did nurses. While nurses were better able to describe hypothesized reasons for the nurse's inability to care, patients were more likely to describe what they experienced without guessing about the nurse's motivation.

1.4.6 Unhappy. Four participants, 2 nurses and 2 patients, noted that nurses who were unempathic seemed to be "unhappy" and "fake." Placed in context with the other descriptors above, those of lack of humor, serious, uninvolved, and preoccupied with their own needs, it is not surprising that the developing composite picture of the unempathic nurse would include the traits of unhappiness and not being genuine.

1.4.7 Anger. Three participants, 2 patients and 1 nurse, described "anger" as a trait of unempathic nurses, relating instances where a nurse lost her temper and took
it out on a patient. The quote above of the screaming maternity nurse is a good example of this quality.

The final two categories were mentioned by only 1 participant, but were felt to be important enough to be included in this theme. The first category, "not learning from experiences," was demonstrated by a an outlying nurse participant. In relating an incident with a patient's family, she made the following observations.

NO16: I guess for one thing I couldn't put myself in that place... in that position... it must sound judgmental -- but what he was saying seemed so outlandish to me and I couldn't have imagined thinking that way. It just wasn't rational, it wasn't realistic. Sometimes you pretend you're empathic when you aren't. (What would you do differently next time?) Nothing, except maybe change the players. (laugh)

The final descriptor, that of being "lazy," was described by a patient who called one nurse a "con artist," who used an overly sweet approach to compensate for her laziness.

PO05: She was very lackadaisical, very forgetful. She was nice, but she was very nice in a conning sense of the way, to try to cover up for her laziness.

2.0 The professional. Participants also described inhibiting attributes that were felt to be more in the professional, rather than the personal, arena. These are divided into the same four themes as were described in the preceding section.

2.1 Communication. In the professional sense of communication, unempathic nurses were seen as "not teaching" patients necessary or important information. The patient
who identified this as a lack in an unempathic nurse she encountered learned what she had not previously been taught from another nurse during a subsequent admission.

2.2 **disengaged.** As mentioned above in the description of personal attributes of the unempathic nurse, "distant" and "uninvolved" nurses were again described. In the professional sense, these nurses were distant to patients. In the personal sense, these nurses established relationships with their peers and other health care workers, but did not value or facilitate nurse-patient relationships. One nurse connected this characteristic with a "task-oriented approach" to nursing care.

N017: Even though all the physical needs were met, maybe there was some type of an emotional need that was overlooked, or maybe never even noticed, because it was so much of a task-oriented approach.

This nurse's patient described how he felt with his nurse as opposed to other members of his renal transplant team.

P017: I felt she (my nurse) was more concerned about me as a person. I'm supposed to be on this team. I feel like I'm the football on the team, you know.

2.2.1 **Robot.** Five nurse participants characterized their peers who practiced nursing in this disengaged manner as having a "robot/mechanical" approach to care. One nurse quoted a friend's mother, a nurse, who she believed practiced nursing in a mechanical fashion.

N014: A girlfriend mother's said, "All you need is a roll of toilet paper to be a nurse." Well, obviously she doesn't get much satisfaction out of
her job and she's doing it because it's a paycheck, and that's her profession by trade. She's a nurse like someone's a mechanic.

2.2.2 Not being there. The final category in this theme, mentioned by 5 nurses and 4 patients, was "not being there." According to patient participants, it was apparent to them when the nurse was not "there." As previous quotes have demonstrated, the quality of being there was important to patients and many patients were able to identify instances when the nurse was not "there." This was attributed to a number of factors, which are discussed elsewhere, such as preoccupation, insecurity, and fear.

2.3 Enmeshed. The enmeshed nurse, the nurse over-involved with patients, was identified by 1 nurse participant as having a professional problem that other nurses might not. That problem was termed "interference." Interference was the phenomena where the nurse would be so involved with 1 patient that this involvement would interfere with her interactions with other patients. As 1 nurse observed her relationship with a terminally ill cancer patient whom she had grown close to, she recognized difficulties with her level of involvement.

N014: If you were like that (very close) with every patient, it would be very difficult and your job would be difficult; you'd have everybody's problems.

2.4 Other qualities. Professional attributes of the unempathic nurse that did not easily categorize into any
of the above groups were assigned to the general first-order theme of "other qualities." In this category are found some negative mirror images of attributes identified in the facilitator section on professional qualities.

2.4.1 Ignore. "Ignore" and "not prompt" were descriptors used by 3 nurses and 2 patients when describing professional qualities of the unempathic nurse. These participants were able to differentiate instances when nurses were busy and unable to attend to them promptly and instances when the nurse simply did not have this quality. Logically, nurses noted this quality slightly more often than patients. A nurse usually knows how busy his or her peers are and can note which call lights remain on for extended periods of time.

2.4.2 Judging. Four patients and 1 nurse noted the qualities of "judging" or "not accepting" as unempathic descriptors. More patients noted this than nurses, indicating that patients are better evaluators of the nurse's attitude toward them. One nurse, an outlier, exemplified this quality with this previously used, but enlightening, quote.

N016: I guess for one thing I couldn't put myself in that place... in that position... it must sound judgmental but what he was saying seemed so outlandish to me and I couldn't have imagined thinking that way. It just wasn't rational, it wasn't realistic. Sometimes you pretend you're empathic when you aren't and that's because you don't agree with everyone. A lot of times when patients give opinions about things, sometimes I don't think they're valid.
From the patient's position, the only attribute more frustrating to a patient than not accepting and judging, was not listening or hearing. There were inhibiting descriptors that were mentioned more often, but none more aggravating or frustrating to patients than not being accepted. Patients could understand or rationalize a nurse not spending time or sitting down with them or being distant and cold. However, not accepting or judging their behavior was very frustrating to patients in the hospital.

2.4.3 Not planning. A mirror image to the earlier facilitating attribute of "planning," 3 patients and 2 nurses noted that unempathic nurses often did "no follow-up," were "inconsistent," and did "not advocate" for their patients. One nurse quote describes the nurse who did not plan for or follow up on patient needs.

NO17: A lot of them do minimal work, what's required to get by in a day, and there's not much more thought in what's going to happen the next day or what can happen next week.

2.4.4 Not knowledgeable. Three patient participants noted that some nurses, in their opinion, had "no knowledge" and were "not qualified" to be nurses and care for patients. These nurses in some cases frightened patients and could cause physical problems for patients. One patient, recalling an incident following bladder surgery, blamed her nurse for a wound dehiscence that required further surgery.
I ended up just busting wide open; I had to have a surgery again! She didn't bother reading in the order. I said, "It had to be opened," that was the problem. If she read the orders she would have seen that the clip that they had on there (the bag) was supposed to be opened; and I said to her when she came back the next day, "You know, I had to go to the operating room to get operated on because of you." I was very irritated at her. I had to come home with the bag for 3 weeks. That set me back so far back. And she apologized, she said, "Well, I didn't realize..." All you had to do was just take the time and read the thing (chart).

These patients were indignant when they encountered nurses who they felt were not knowledgeable or unqualified. They also were more than a little frightened to be under one of these nurse's care.

2.4.5 Intense emotions. The last attribute in this category was mentioned by 1 participant, but was included because it was felt to be an insightful addition to this category. One nurse participant identified "intense emotions" as being an inhibitor to nurse empathy. She believed that being wrapped up in your own emotions inhibited your ability to be open to others.

N015: I try and make myself aware of my own anger or my own feelings about a situation to try and decrease it or minimize it if possible, to improve communication. It doesn't always work. (Why doesn't it work?) Because I just get so emotional and so mad at something that's going on, that I can't believe that it's even occurring. Sometimes I feel like I don't make people feel comfortable around me. Usually that's when I'm very upset about something.

Summary. The inhibitors to nurse empathy were usually used to describe unempathic nurses or behaviors that
participants ascribed to unempathic nurse. While participants readily agreed that any nurse, under certain conditions, might exhibit one or more of these attributes, they also agreed that nurses who habitually behaved in these manners were not demonstrating nurse empathy.

Summary of Question One

In answer to the first research question, "What is and what conveys nurse empathy from patient and nurse perspectives? How do these perspectives compare?", the previous sections have been offered. Such a mass of information is overwhelming and difficult to assimilate and the researcher developed a conceptual perspective that allowed incorporation of much of the information gained through content analysis. The first component of this conceptual perspective is presented as personal and professional facilitating and inhibiting characteristics of the nurse in Appendix F. This drawing includes all attributes, positive and negative, ascribed to the nurse. The circle represents the complete nurse. The dotted line between "the person" and "the professional" halves of the nurse acknowledge that there is a great deal of interplay between these two components of the nurse's behavior and style. The circle is further divided into a positive half and a negative half, with the positive half including facilitating attributes and the negative half including inhibiting attributes. A complete list of attributes for
each section of the nurse circle are listed in Appendix E, under the headings "Nurse Empathy Facilitators" and "Nurse Empathy Inhibitors."

**Research Question Two**

Research question two asked,

> What influences patient satisfaction with nursing care from patient and nurse perspectives? How do these perspectives compare?

In asking participants what they believed influenced patient satisfaction with nursing care, nurses and patients offered their opinions and allowed the researcher insight into their individual preferences and needs. As mentioned, 10 patients had been hospitalized prior to the hospitalization resulting in their participation in this study and all nurses had either personal hospital experience or had had a close relative in the hospital. Therefore, all participants may be seen as actual, potential, or former patients and recipients of nursing care.

Participants offered both facilitating and inhibiting descriptors to explain what influenced their satisfaction with nursing care that were, in essence, identical to the descriptors of nurse empathy. In the interest of brevity, only those factors that were different from the nurse empathy facilitators will be identified and discussed here, with appropriate participant quotes. A summary figure that presents the patient satisfaction facilitators and
inhibitors may be found in Appendix F.

**Facilitating Factors**

Factors seen by participants as facilitating patient satisfaction with nursing were divided into second-order themes that include physical improvement, attributes of the nurse (personal and professional), environmental and circumstantial factors, and finally, patient outcome (patient expressions of satisfaction and patient feelings).

**Physical Improvement**

Only 1 participant, a nurse, mentioned actual physical improvement in condition as a factor in facilitating patient satisfaction with nursing care. This participant believed that patients could assess their physical improvement and would credit nursing care with this improvement. Interestingly, no patient participants mentioned this as a factor contributing to their satisfaction with nursing care.

**The Nurse: The Person and The Professional**

The discussion, descriptors, and categories found in these two themes were similar to the discussion found in the previous section.

**Rapport with the Nurse**

The next theme, rapport with the nurse, describes the quality of the relationship that develops between the
nurse and patient. This is a brief description of satisfiers and the phenomena of nurse-patient relationships will be discussed more completely at the conclusion of this chapter.

This section included previously discussed first-order themes of communication, understanding, listening, touch, familiarity and respect. Familiarity is the only new concept in this category. Familiarity was a term applied to the nurse's familiarity with the patient as a person. This familiarity developed over time, but some nurses were recognized by patients as developing a familiarity with them more quickly. Patients saw the expeditious development of familiarity as an important satisfier because it saved them the effort of explaining their needs in detail repeatedly to unfamiliar caregivers. Patients correctly perceived that nurses who were familiar with them and their needs communicated this information to other nurses.

Environmental/Circumstantial

Factors that influenced patient satisfaction with nursing care that were not related to the nurse herself were deemed environmental or circumstantial factors. While some of these factors were institutionalized, or inherent in the facility due to their practice model and nursing philosophy, other factors were purely circumstan-

tial.
Time to sit down. One of the most frequently mentioned satisfiers was that of the nurse having time to sit down with the patient. The study facility's primary nursing practice model and a generous nurse-patient ratio allowed the nurse to spend more time with the patient. Nurses and patients both agreed this was a satisfier.

Primary nursing. Four nurses and 5 patients identified primary nursing as a patient satisfier. The 5 patients who mentioned primary nursing as a satisfier had had prior hospital experience with other care delivery systems. They preferred primary nursing because they knew there was one specific person responsible for their care and well-being.

Consistent nurses. Similar to primary nursing, 4 nurses and 1 patient identified the assignment of consistent nurses to a patient as a satisfier. The 1 patient who mentioned this factor had not experienced team nursing, but was commenting on consistent nurses other than his primary nurse.

Housekeeping personnel. As most nurses are aware, the cleaning personnel in a hospital can be important people to the patient. The housekeeper can establish a non-threatening relationship with a patient and also communicate with the patient as one lay person to another. One patient mentioned the sweet cleaning woman who spoke with her every day and inquired about her health and progress.
Outcomes: Expressions of Satisfaction and Reciprocity

While these patient expressions of satisfaction are not truly patient satisfiers, they are presented here as a result of the patient's satisfaction with nursing care. The term reciprocity is used in this sense to identify those acts by patients that attempt to achieve a balance in the nurse-patient relationship. Reciprocity may take many forms, but was most often expressed by way of letters of thanks and thank-you cards, gifts of candy, and in one case, a dozen red roses that Patient #17 sent to his primary nurse. A nursing publication of the facility featured a cover article, written by one of the study participants, entitled "Reciprocity: To Receive is a Way of Giving" (reference withheld to maintain anonymity of the participant). The author discussed a qualitative study conducted by members of the nursing staff that examined randomly selected, voluntarily submitted patient letters of thanks. Reciprocity is of such magnitude in this facility that it merits special attention and mention in this study.

In a sense, the researcher was a beneficiary of this reciprocity. More than one patient acknowledged that one of the reasons they agreed to participate in this study was to be able to "give something back" to the nursing profession, or because "you said you interviewed my primary nurse. If she's willing to spend the time, the least
I can do to spend the same amount of time with you for her (the nurse's) sake."

There is a strong tradition in the study facility of gift-giving. Plaques identifying the benefactors of the facility are prominently displayed on equipment, doors, walls, elevators, and buildings. Wings and floors of the facility are named for individuals or families who donated funds to construct these areas. The names of major benefactors are engraved in the concrete canopy surrounding the main entrance, with ample room for the addition of new names as needed. Gift-giving in this facility may be related to the facility's affiliation with Judaism, which also has a tradition of generous gift giving for significant events throughout a person's life. A hospitalization may be seen as a significant life event and the generosity of the study facility's benefactors may be a reflection of this tradition.

Certainly the precedent has been set for reciprocity in this facility and patients responded by sending thank-you cards and letters (mentioned by 2 nurses and 1 patient), gifts and flowers (mentioned by 3 nurses and 1 patient), and having relatives bring candy or edible gifts on their day of discharge (mentioned by 1 nurse). These cards and letters were prominently displayed on the units and edible gifts were noted in all staff rooms throughout the researcher's 2 month data collection period.
Patient Feelings

Another result of patient satisfaction is the expression of patient feelings upon discharge. One patient expressed an appreciation of his care and noted how "impressed" he was with the nursing staff at this facility. Another patient mentioned that she had recommended this facility to her friends subsequent to her discharge and positive experience at the facility.

Inhibiting Factors

Factors that inhibited the patient's satisfaction with nursing care and subsequently the hospital experience were, again, similar to those descriptors identified earlier as nurse empathy inhibitors. These inhibitors were specifically mentioned by patients or nurses as having a direct effect on patient dissatisfaction with nursing care. At the completion of this chapter, more factors that would result in patient dissatisfaction are discussed in the section entitled "relationships."

Nurse Treatment

How the nurse treated the patient was an important factor in determining how the patient felt about his or her hospitalization and nursing care. A list of these descriptors may be reviewed as a listing in Appendix E and as a graphic illustration in Appendix F.
Patient Feelings

Patient participants described how they felt when they had been treated poorly and were dissatisfied with nursing care. As may be expected, the helplessness and vulnerability associated with hospitalization and illness exacerbated their anger and frustration in these situations. These feelings and descriptors were: "angry/mad," "anxious," "frustrated," and "no trust/no confidence" in the nurse.

Summary

To summarize the responses to research question two, it must be noted that nurse and patient participants were remarkably congruent in their descriptions of patient satisfaction. More remarkably, most descriptors of patient satisfaction and dissatisfaction were identical to those descriptors used to describe the empathic and unempathic nurse. While patients were more likely to use simpler, concrete terms, nurses relied on their extensive vocabulary about nurse-patient relationships to explain similar concepts.

It must be noted that the numbers of patients mentioning the dissatisfiers usually were fewer than the number of nurses mentioning the same dissatisfier. While patients were not exactly reluctant to report negative experiences and impressions about nurses, the researcher was aware of a certain level of restraint used by many
patients. Some patients categorically refused to offer complaints or negative observation about their nurses and other patients recounted unpleasant experiences with nurses from many years before. Nehring and Geach's (1973) premise that patients do not complain about negative nursing experiences appeared to be substantiated in this study.

There exists a striking similarity between nurse empathy facilitators and inhibitors and patient satisfaction facilitators and inhibitors. Appendix E lists patient satisfaction facilitators and inhibitors under the sections corresponding to the above categories. Patient outcome descriptors are diagrammed in Appendix F. The comparison between the responses to research questions one and two will be addressed in the next section.

Research Question Three

Research question three asked,

What is the relationship between nurse empathy and patient satisfaction with nursing care from patient and nurse perspectives? How do these perspectives compare?

The answer to this question is the key to this study. Is there a relationship between nurse empathy and patient satisfaction? Responses from nurses and patients would indicate that there is a positive relationship between these two factors; that is, if the nurse is empathic, the patient is more likely to be satisfied with the care
patient is more likely to be satisfied with the care received. This statement, however, is fraught with numerous conditions. While 8 nurses believed nurse empathy and patient satisfaction to be correlated, 5 believed that these factors were either conditionally or mildly correlated. In other words, nurses could see a correlation between empathy and patient satisfaction, but were quick to point out that there were many other factors to consider when accounting for patient satisfaction. The most prominent of these other factors will be addressed in the conclusion of this chapter.

Four nurses and 2 patients believed there was a "strong correlation" between nurse empathy and patient satisfaction. Four nurses and 1 patient believed a "mild correlation" to exist between nurse empathy and patient satisfaction. It is interesting to note that 3 of the 4 nurses who believed in a strong correlation were interviewed chronologically earlier than the 4 nurses who believed the correlation to be mild. The researcher may have modified her questions as interviews proceeded to such an extent that nurses were more cautious about stating a strong, positive correlation between nurse empathy and patient satisfaction.

Nurses who believed strong correlations existed between nurse empathy and patient satisfaction are quoted below or elsewhere in this section.
N008: Yeah, I think that there is definitely a connection. I think that ... it all depends on the patient's perceptions, but if the patient knows that you're there for them, you care for them; I think that, no matter what situation, they feel very satisfied with what happens.

N001: Do I think that there's a connection between nurses' empathy and patient satisfaction? Oh, definitely. If you're not empathetic with patients, I think that patients are aware. I think there's definitely a relationship. Patients ... are aware, and when they feel like people care about them, I think it helps them to help themselves. There definitely is a connection. I think it's innate within ourselves to want to be cared for and want to be understood. So I think that definitely makes a difference.

It is interesting to note that 2 nurse-patient pairs responded in similar manners to this question of correlation. Nurse-patient pair #5, the closest and longest-lived relationship of the study sample, both agreed there was a strong correlation between nurse empathy and patient satisfaction.

N005: There has to be that connection, that the patient walks away sensing that someone heard them and was empathetic to their needs and they're going to walk away feeling ... a little bit more able to manage on their own. So there is a connection (between nurse empathy and patient satisfaction). Absolutely.

P005: (Do you think there is a connection between nurse empathy and patient satisfaction?) 100%. I really do. She (my nurse) knew (me), but I was open and expressed myself to her often enough that she was able to pick up on the way I was feeling, and how I would react.

Another nurse-patient pair shared the opinion that nurse empathy and patient satisfaction were related, but were not as certain as to the strength of the relationship.
This nurse-patient pair was more typical, in that they had met during the hospitalization resulting in their participation in this interview. While the nurse was certain a relationship existed, the patient was more reserved in her opinion.

N014: (Do you think there's a connection between nurse empathy and patient satisfaction?) Yeah, of course I think that. That there is... They get bad attitudes about hospitals ... when they don't feel that people care about them. And don't empathize with their problem (So there is a connection?) Oh, yes. I think that's clear.

P014: (Would the nurse's empathy make you happier with your nursing care?) Oh, I think it would. In a way. She (my nurse) was ... in my shoes, she understood what I was going through. Yeah. (Do you think there would be a connection there?) Could be.

One nurse believed the correlation between nurse empathy and patient satisfaction relied upon the condition of perceived empathy. She believed if the empathy was not perceived by the patient, patient satisfaction would not occur.

N002: If the communication comes across, if you feel empathy and ... you're able to communicate that, and the patient is able or willing to hear -- or experience that -- then, I think, it's going to be a real strong correlation with satisfaction; and you'll probably find you have a very satisfied patient. You can also have a very empathic nurse and a very dissatisfied patient if the communication doesn't happen, for whatever reason. I definitely think that it's cause and effect, and that the case where it works, in the sense that ... there was an empathic, well, that there was a back and forth, a mutual, felt thing is what makes it work. I think it is an art, this back and forth between patients and nurses who are genuinely empathic.
It was interesting that 2 nurses admitted they had not considered this correlation until becoming involved in this study.

N017: The nurse's empathy and the patient's satisfaction? Well, I know that if I was on the bed and someone came in and could try to relate to what I was feeling, saying, doing, my actions, words -- verbal or nonverbal -- just to have someone attempt to make that connection with me; I think would make me feel good, versus someone who may just want to get the task done. I'd say yes. I never really have thought about it. (pause) I'd definitely say yes!

Attributes contributed by participants describing nurse empathy and descriptors of patient satisfaction were compared. Virtually all patient satisfaction descriptors related to nurse characteristics were found to be the same as nurse empathy attributes. Half of the facilitators of empathic nursing were also found to be facilitators of patient satisfaction. Similarly, the inhibiting factors for both nurse empathy and patient satisfaction were found to be similar. Appendix G lists all the descriptors, in alphabetical order, that were congruent between the two groups of attributes.

Research Question Four

Research question four asked,

How does information obtained from key leader interviews and artifactual evidence compare to what patients and nurses say about nurse empathy and patient satisfaction?

Content analysis from key leader interviews and artifactual information supported the nurse empathy categories
and themes and patient satisfaction categories and themes identified in nurse and patient interviews. Relationships between nurses and patients were considered important by all interviewed leaders and analysis of artifactual data indicated that the development and maintenance of nurse-patient relationships were supported culturally in the facility.

Content analysis of artifactual information indicated a support for nurse-patient relationships within the facility. A review of the nursing philosophy, developed originally in 1974 and updated over the years, indicated a priority for ensuring that "each patient receive professional nursing care that is patient-centered and goal-directed, while supporting nursing and other health care education and research." The study facility has espoused Virginia Henderson's theory of nursing, advocating

Professional nursing (as) a complex service that assists people (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge. (Henderson & Nite, 1978, in anonymous study facility document)

As a reflection of the importance of the patient, the study facility was the first institution in the country to formulate, adopt, and distribute to patients the now-standard "Patient's Bill of Rights." Developed by the hospital's President (a physician) and published in 1972, a copy of this list of rights is included in every patient's
admission packet.

Artifactual information was gathered from nursing services by special request and from other easily available sources. Nurse evaluation tools and advancement criteria clearly specified the need to work effectively with patients and families. Unsolicited letters from patients to the study facility were reviewed and also revealed an emphasis on those descriptors described above. An analysis of a month's quality assurance audit examining patient teaching and patient knowledge of continuing care for the six medical and surgical units from which nurses participated in this study indicated that an average of 75% of patients knew their primary nurses' names, with a range of 40-100%.

A review of a report on exit interviews from 1985-1987 indicated that almost 50% of nurses leaving the study facility did so due to relocation needs and not because of the professional nursing climate. Nurses accepting positions at other facilities was the next most frequently cited reason for leaving. In listing negative experiences during the exit interview, the two prominent negative experiences of leaving nurses were inadequate and expensive parking facilities for nursing staff (finding a place to park is a notorious problem in the study facility's home city), and an unsatisfactory work schedule that included rotating shifts, weekends, and holidays.
The hospital's magazines, reports, and newsletters focused on communicating information to employees, patients, and benefactors of the hospital. One publication was directed toward and written by the nursing department. The three editions available to the researcher were analyzed and reflected the department's interest in communicating in-house nursing research findings and introducing new department members to the readership. Each issue had one to five photographs of nurses and their patients.

Recruitment information and literature repeatedly identified the patient as the most important individual in the hospital and the nurse's purpose as meeting the needs of that patient. Photographs for hospital advertisements were usually of nurses and patients, both enjoying a laugh or a smile, with the nurse and patient in close proximity to each other or touching. In an interview with one key leader affiliated with recruitment, the researcher inquired about the photographs and how they were set up. The key leader indicated that photographs were never posed, and the nurses were simply told to interact with their patients in their normal fashion. The resulting photographs were warmly intimate and spontaneous. These photographs and advertisements were contrasted with other hospitals' recruitment photographs showing a group of nurses working over an inert body in an obviously staged emergency situation or picturing a group of nurses.
socializing outside of the hospital. The recruitment aids from the study facility were singular in their positive depiction of and focus on nurse-patient interactions and nurse-patient warmth and mutual positive regard.

Content analysis of interviews with key leaders was supportive of categories and themes obtained through analysis of nurse and patient interviews. Key leader interviews touched on an array of topics, but analysis was confined to topics of nurse empathy and patient satisfaction. While no new categories were forthcoming from these interviews, they provided additional insights into nurse empathy and patient satisfaction from the administrator's perspective. Leaders were asked how, in their present position, they were able to influence nurse empathy and/or patient satisfaction. Responses were universally related to providing support of and for the clinical nurse in her caregiving efforts with patients. Two nurse managers interviewed offered additional insight into the personal and professional growth of nurses who were described earlier as disengaged or enmeshed. The evolution of the empathic nurse will be discussed in Chapter IV.

In summary, analysis of key leader interviews and artifactual evidence added the depth of another dimension to the study. Reviews of artifactual evidence and key leader interviews implied there was an institutional culture supportive of the nurse-patient relationship. All
interviewed key leaders consistently utilized the facility's philosophy of patient care being the prime directive of the facility when explaining their roles in the nurse-patient relationship.

Research Question Five

Research question five asked,

Is there a relationship between quantitative data and qualitative data obtained about nurse empathy and patient satisfaction with nursing care?

As mentioned previously, quantitative data were not collected for purely statistical reasons, as the sample size was not anticipated at the outset of this study to allow such analysis. Thus, the quantitative results did not add significantly to the understanding of the data except in a strictly individualized, anecdotal manner. Comparison of individual participants' scores with content analysis of their transcripts provided further insight into priorities and interests in some cases.

Scores of nurse participants whose interview responses were identified as outliers were closely scrutinized to ascertain if the researcher's assessment of their status as outliers was substantiated by their test scores. Nurse #16, with a master's degree in nursing and whose quotes were used as negative examples of nurse empathy in earlier sections, was noted to have the lowest LEP score (40 in a range of 40-84) of all 12 nurse participants. However, her BLRI score was 16, in a range of 1-30. There were four
scores lower than 16 and seven scores higher. Comparing her corresponding patient's scores with other patient's scores indicated that the patient perceived her nurse as empathic. The patient's BLRI score was 39 in a range of 6-42. There were two scores higher and nine scores lower than 39. The patient's PSI score (total) was 114, in a range of 91-125. There were five scores higher and six scores lower than the patient's 114.

Another nurse outlier, the nurse who had been raised in an unempathic environment and had taught herself to be empathic after becoming a nurse, had BLRI and LEP scores in the midpoint of the ranges. Interestingly, the LEP subscore for nonverbal behavior was the lowest in the group (5 in a range of 5-26) and the perceiving feelings and listening score was the highest (20 in a range of 4-20) in the group. These findings correspond with content analysis that revealed this nurse communicated her empathy by very attentive listening and was concerned that patients would perceive her as uninvolved because of her extremely organized, methodical approach to patient care.

The 2 nurses whose patients had expressed a concern that the nurse might become too close or too involved had interesting BLRI scores when compared to their patient's scores. The nurse with the highest BLRI score (30 in a range of 1-30) was paired with the patient who had the lowest BLRI score (6 in a range of 6-42). This patient
Contrastingly, the other nurse-patient pair had scores of 23 and 24, respectively, with both scores in the midpoint of each range. In view of this interesting information, the researcher compared each individual score with what she knew about the participant through content analysis of interviews. However, a close inspection of individual scores for all quantitative instruments did not add to the understanding of information obtained earlier from content analysis.

Serendipitous Results

"Serendipity" is defined as finding valuable or agreeable things not sought for. This study had a number of serendipitous findings that did not answer a specific research question. However, these findings offered valuable insights into nurse-patient relationships and patient satisfaction. The findings are broken into five third-order themes. The first theme contains findings generally related to the issues of nurse empathy and patient satisfaction, and is entitled "Supporting Information." The next three sections are "Personal Characteristics," "Relationship Factors," and "Nurse Satisfaction." In the interest of brevity, each section will include a brief discussion of the unexpected finding, a few illustrative quotes, and reference to Appendix F, which contains illustrations with listings of the attributes.
Supporting Information

Information that was supportive of the study concepts, but not directly related to the relationship between nurse empathy and patient satisfaction, is listed and described here. This information was important to the study in that additional insight was gained into the phenomena under scrutiny and the researcher was also allowed to identify areas for future study.

Nursing Art and Nursing Science

Nurse participants often asked the researcher how she became interested in the topic of nurse empathy and patient satisfaction at the beginning of an interview. The researcher's interest in better understanding the "art" of nursing was the impetus behind this study and nurse participants had their own insights into the art and the science of nursing. Basically, their views on the differentiation between the art of nursing and the science of nursing were similar to the researcher's. A few patients who were more interested in abstract concepts also shared their views on the art and science of nursing. A few selected quotes are presented here. A complete listing of serendipitous results may be found in Appendix E under the category of "Supporting Information."

N001: The art of nursing is the psychosocial and the science of nursing is the physical. The art gets lost because of the physical demands of the science. I think that we (study facility RNs) shine because we don't have the load of six or
seven patients. And when you have that demand on your time to care for six or seven patients every day, you don't have the time (to) carry out your tasks in an artful way with each of those patients. You need a lot of time to sit down and practice your care in an artful way. Sometimes I just have to do the nuts and bolts.

N005: The science. I spend a lot of time doing the science, the day-to-day physical assessment, looking at labs, seeing what's going on in terms of bodily function, what needs to be managed in terms of fluids and electrolytes, and hematological things; that's more the scientific part. But then you get into other type of nursing problems such as pain and coping and that's where empathy becomes more important. I can look at someone's labs and do an assessment and take care of them without being empathetic, and it's not an emotional type of thing, but when you're dealing with pain and dealing with coping, then the art of nursing comes into play and being a big part of making those problems more manageable.

P016: I think the science part is, there is just one way to do it, and the art part is a lot of ways to do it. I think that is what makes it art, that makes it different; art is different in any way. You know each thing is not the same. There's just so many ways you can do it that aren't exactly the same ... because I'M not (the same).

P017: There's book smarts and there's street smarts. And, in most cases, I'll take the person with the street smarts. Because I think they just understand life better. I've know some real smart, book smart people, and I wouldn't walk around the corner with them. They’re just dangerous. They do the wrong things and they say the wrong things. They don't know, they're in a little vacuum.

Teachability of Empathy

Nurses and patients had various responses when asked if empathy could be taught to nurses. Patients often said this quality of empathy was a "gift," an inherent quality that could not be taught. Nurses more often believed em-
pathy was the result of being raised in an environment where empathy was valued. Nurses believed empathy could be modeled and developed, but not "taught" in the didactic sense. In support of this, one nurse spoke of how she set about to develop this quality of empathy because she admired a nurse who exhibited empathy in her nursing practice.

The first three quotes are from participants who believed empathy is teachable to others. The second group of three quotes describe reasons why empathy is not teachable. The final two quotes, both from patients, describe how they believe this quality is a "gift" and, as such, is not truly teachable.

**Empathy is teachable.**

N001: Yes. I think you can teach someone (how to be empathic). Our family is real close; and some people are brought up in a very supportive environment where they had empathy from their parents so it's an integral part of themselves. And of course there are people who haven't had that and it's hard for them to give or to try to understand others. I think (they can learn it) if there's a want within the person to be empathetic. They have to want it. I think they say, "I want to be able to communicate with my patients better, I want to understand them," and that's being empathetic already.

N002: Do I think this quality can be taught? I tend to think -- yes. I do. I definitely don't think you're born with it, I think you learn it. I didn't grow up in a real touchy family and I've sort of had it as part of my own personal growth to just be more physically close with people. Some people may have grown up in a way that it comes to them a little more naturally and some people may have to put a little more effort into learning it, and not everyone chooses to. You can
learn it. A lot of those things that I do to communicate empathy I have learned how to do, but somewhere I wanted to be able to do it. So I believe that people learn, cause I know I have.

P015: It can be taught. I think that we all are into nurturing and caring. I think it really is inborn, and then you toughen-up, or you find what your defenses are. The skill can be taught. I think you can develop people skills, and how to listen. I think those things can be taught. I think the other things need to be reminded. You just have to remind people that it's good to be compassionate.

Empathy is not teachable.

N010: You can't teach empathy I don't think, really. You can teach what it is, but there are some people that aren't empathetic. I think that most of those people would not go into nursing.

N011: I don't think you can teach it (empathy). You can teach them all the actions. You can go through it. You're not going to get the same responses. And the people you interact with are going to know that.

P002: You can't teach that sort of caring for people and that being willing to connect with people. I mean, if you're not a people person, you don't make a very good nurse.

Empathy is a gift/inherent.

P005: I just can't believe that (my 2 nurses) were trained to be the way they are, the people that they are. (Do you think its just natural?) I think that there's some nurses that have chosen the wrong fields, that they are probably very intelligent as far as technology, information, and knowledge, where it comes to compassion -- they don't belong there (in nursing). (Where would you send those nurses?) Where would I send them? They wouldn't be nurses!

P008: There was just something different about (my nurse). Something special. She has a gift. Nursing school probably contributed, but some people got that from the beginning. (Can you teach this to someone?) I don't think so. Some people have -- a gift. You could take a person and teach them
something and they can go by the book ... they can be nice, they could be personal or be impersonal. But you got some people, it's just there. And it's just something we just click with, and she was one of those people. We clicked. She's got a gift. Everybody don't [sic] have that. I think you can teach all you want, it's what inside the person that really comes out.

Development of Empathy

Similar to the previous topic, teachability of empathy, study participants offered insight into the natural development of empathy. Nurse participants attributed a part of their empathic development to personal and professional experiences and, most importantly, to a willingness to examine their experiences to gain new insight about themselves and into their relationships with others. Three quotes describing professional experiences and growth are offered here to further illustrate this concept.

N005: I would tell nurses that (empathy) is an art -- that it is something that needs to be developed with time. Some people have the gift of it, but I think for most of us it comes with experience. But it's an art that behooves you to work on a lot, because it is such an important part of what we do. Give yourself time to stand back and watch, look back at situations and learn from them, but it's hard. It'd be easier if we could just take care of the person and not see that.... (I would tell them) to allow the patients to teach us actually what it is all about. I think that's why it's something that develops over time because patients teach you. They let you know if they think you're there, or if they think you've missed the mark.

N014: In the beginning, you're so into learning the science. It's (empathy) something that starts to come as you've been practicing and you're into
doing the tasks and feeling good that you've completed the tasks; and everyone's safe and alive at the end of the day and I did my job. But then, the more you get into it, your job is something different. You feel, "Is that all I've done, is giving meds?" You come to a point where that's not enough in your job. And it's the contact that you have with patients and you realize the feedback that you get from that -- it's more of a feeling, it's not something that you can describe. And it's seeing that you make a difference in somebody's day and you're the person, when they come in they look forward to seeing you and sitting down with you and telling you what's happening.

One nurse described a vividly recalled situation where she probably became enmeshed with the patient and began to experience shortness of breath with the patient. It is interesting to note she remarked that she could not imagine putting herself in the patient's situation, even while describing her symptoms. While she may not have been able to empathize on an intellectual level, she may have been sympathizing on an emotional level. She was able to look at that situation, contrast it with her current nursing practice, and identify what she learned from this experience.

N017: (When I was a new student, I had) this one patient who could not breathe. And as he could not breathe and his family got more anxious, I got more anxious; and it was almost as if his symptoms were becoming my symptoms. I guess that just left a lasting impression on me, what an awful thing not being able to breathe. But also, what an awful thing for anyone who's there. The things that they did were so invasive. And then that feeling got brushed aside and I guess that was my first piece of really kind of being "wow-ed" by the profession. What a great profession, but how much control we had, and then that poor patient. I couldn't even imagine putting myself in his place. All I knew were my own symptoms of, "I
can't breathe because he can't breathe," and that was awful. I look more now at the patient. I was so overstimulated by all the medical things that were going on, I guess until afterwards I really didn't focus on my own needs. But now I look at the patient underlying all those other people in the room and, although he or she is getting short of breath, trying to talk them through it. I think sometimes I talk them through it to talk myself through it.

**Purpose of Nurse Empathy**

Some participants identified specific purposes for nurse empathy, other than patient satisfaction. One identified purpose of nurse empathy was preventing burnout and facilitating nurse satisfaction with nursing as a profession. However, this purpose was considered of such importance, it is discussed in another section below. The other identified purposes for using empathy in a patient care situation were identified by participants as: caring, comforting, help/make an impact and to speed recovery.

**Role Model**

During the interview, nurse participants were asked to identify a nurse, or nurses, who had been role models for their professional development. It was interesting to note that the few nurses who identified themselves as more "into" technical and tasky aspects of patient care looked to role models who were particularly good at people skills. Equally interesting was the observation that the naturally warm, empathic nurses chose role models whom they believed were technically and organizationally
superior. There was some evidence of the nurse's attempt to balance her practice of the art and science of nursing through her choice of role models.

One nurse identified a younger and less experienced nurse, also a participant of this study, as her role model. The researcher felt this young nurse was a naturally warm and empathic person and, unlike some of the more experienced nurses, had not given much thought to the concept of nurse empathy. The older nurse described the younger nurse as a "Sibyl," referring to a novel about a schizophrenic young woman with multiple personalities.

N017: She really seems to put herself in the person's shoes, but also the family; it's like she's -- a Sibyl. She puts herself in the patient's shoes, then she puts herself in the family shoes, and then she tries to look at it from a social worker's point of view with discharge -- and then she's a nurse, and then she tries to communicate with the doctor.

Another nurse identified her role model as being very organized. She believed she did not have this quality of organization and set a goal for herself to become more organized. This was the nurse who observed if one is organized in nursing care delivery, one has more time to spend with the patient.

Possibility of Nurse Empathy

A topic that frequently arose during interviews was the possibility that the nurse could truly understand an experience from the patient's perspective. Study partici-
pants had contradicting views on this topic. While some nurses were more likely to believe that they were able to understand a patient's experience, most patients said the nurse could never truly understand what it was like to be "in their shoes." Most participants' views fell between these two extremes, with the belief that common human experiences allowed nurses to understand a patient experience -- within limitations. Participant quotes are offered to better illustrate these viewpoints.

NO10: (A nurse describing her interactions with her terminally ill primary patient.) I get uncomfortable because I'm not experiencing death the way she is. No matter how empathetic you can be, I don't think I'll ever truly know what she's feeling in that kind of situation. I don't think you can ever understand unless you go through it yourself.

NO17: I think we use words like or statements, "I'm trying to understand what you are going through" or "I know what you are going through," or "I know how bad it is." And I've had patients turn around and say "No you don't know, you're not here." And even though we try to understand, I don't think we'll ever be able to perceive what another patient really is feeling or going through. You just never can perceive or feel what they feel, so you do the best you can with the limitation you have.

NO11: We'll never understand because you don't know what happened to these people as children or as young adults. And you don't know the dynamics of their marital relationship, or their relationships with their children. I just think there's no way that we can possibly know all that. We only know as much as they tell us, or let you know. And people don't always want to divulge all that.

One younger nurse, in describing trying to empathize with patients, alluded to becoming sympathetic and "feel-
ing with" the patient, rather than "feeling for." This nurse was identified by the researcher as naturally empathic and had not thought about the concept of nurse empathy very much. She had this to say about the ability of the nurse to be empathic.

N004: There are just some people who ... you might really be able to kind of feel what they're feeling, or see what they're going through, and they're just the type of person who can't see that someone else could imagine what they're going through. "It's happening to me, you can't imagine." And you probably really can't imagine, to the fullest, what it's like to somebody to live under some of the situations that we see. We've never been in them. Maybe some people really think that no one else can feel the way I feel. But, you can try to, and come close, maybe.

Patients had these observations about the possibility of nurse empathy.

P008: (a patient who had experienced a miscarriage) I RESENT people who say, "I understand." You don't understand unless it happens to you. (My nurse) didn't say, "Well, hey, I understand what you're going through," she would say, "Linda, look, things happen." She would say, "I can't say that I understand, but, look at it like this way. Maybe next time, I'll be here, and you're going to let me know, and we going to celebrate." 'Cause you could try to put yourself in my place, but you could never be able to understand it.

P015: (a newly diagnosed AIDS patient) I don't think a nurse should ever say, "I know how you feel." How DARE you presume to know what I'm feeling? Even right now we're communicating, I think we are understanding each other. (But no one can really understand what it's like to be in your position?) No, of course not! I have trouble understanding what it is like to be in my position. But I think that's not what people mean when they say that. They think "I've gone through it." There is nothing in the human experience we don't understand. We all know love, fear, hate, joy, disappointment. These are things that we all
experience. So, that's what they mean. I know that's what they're saying, is that "I have felt these things too." But the patient, of course, who is so understandably self-obsessed, resents it. "These are MY feelings. This is MY illness." So, I think it's something for nurses to examine is how do they make it clear that they're not trying to take the illness away. What it is is that "I too have been in pain."

One nurse outlier, the nurse who identified herself as someone who would pretend empathy on occasion, missed seeing the opportunity of mutual self-disclosure with patients. She had this observation about communication of empathy to patients.

NO16: You can't say to someone, "I think I would know what you feel like," or anything like that because it's not valid, unless you have been in that situation. But even then, I don't think it's fair to share a personal situation with a patient, because they think you're serving your own purposes sometimes instead of the patient's by doing that.

Ultimately, nurses agreed that empathy was enhanced by personal experience. As mentioned above in the section of development of empathy, the nurse's willingness to learn from personal and professional experience is an important factor in empathy.

NO05: I do know a lot of what it's like to be around someone who's ill, or someone who's emotionally demanding. I know what it's like to be left alone, and all those things. And I think even though I can't perceive exactly what they're going through, the general feelings that they express sometimes, I've felt them in my own life. And that helps me then to better understand the hurt involved or the pain involved and what they're going through.
Possibility of Patient Satisfaction

One question asked of participants addressed the issue of the possibility of the patient being satisfied with nursing care if their diagnosis and/or prognosis were unsatisfactory. Participants unanimously agreed satisfaction with nursing care was possible and agreed that patients could differentiate between their poor diagnosis/prognosis and the care delivered by nurses.

Possibility of Patient Evaluation of Nursing Care

Participants were asked if patients were able to evaluate their care, in view of the fact that patients were not always cognizant of why nurses performed certain acts. With the primary nursing care delivery model in the study facility, much of the nurse's activity and coordination would not be visible to the patient. Participants agreed that patients are able to evaluate the quality of their care and do evaluate this care. Furthermore, patients maintained that they were the best judges of their care and one did not need to be an "expert" to evaluate nursing care. As one nurse said, "The patients know if, 'Yeah, this nurse did right by me,' or 'No, this was not good.' They can tell."

Personal Characteristics

Content analysis revealed interesting information about characteristics of nurses and patients involved in
the empathic nurse-patient relationship. While more descriptive information about the nurse-patient relationships is outlined in an ensuing section, the characteristics of nurses and patients is presented here.

**Attitude**

Nurse participants were asked to describe a patient care situation where everything seemed to work well -- an instance where the nurse and patient communicated, needs were met, and everyone was satisfied with the result. Characteristics of individuals involved in these relationships were remarkably similar to those characteristics described as belonging to empathic nurses. Additionally, a positive attitude of both patient and nurse was mentioned repeatedly. Attitude became a minor thematic undercurrent in this study, nurses and patients with positive attitudes were generally happier and easier to work with, while people with negative attitudes were more difficult. While the importance of attitude is not a radical or new concept, participants believed attitude plays a major role in determining the patient's satisfaction with nursing care, as well as nurses' satisfaction with their profession.

**Socioeconomic Status**

Interestingly, the only socioeconomic factor mentioned in this study by either nurse or patient participants was
that of wealth. When nurses were asked to identify a patient care situation where things did not go well, one of the frequent negative descriptors was "VIPs" or very important persons, and "wealthy" or "rich." Nurses recounted instances where they were quite literally expected to sweep floors or hand a patient a glass of water that was readily within reach, by patients who were demanding and expecting maid-like service from the nurse. Nurses resented being patronized and treated as servants. It is interesting to note that the nurses who took exception to this behavior by patients were unable to empathize with what might be seen as the well-to-do patient's feelings of helplessness and vulnerability and see the patient's demanding behavior as a symptom of a patient need. Nurses often said they felt these people did not deserve special treatment simply because they had donated money to the hospital and being required to care for these patients and tolerate their behavior was a stressor for three nurses, two of whom worked on the same unit.

Hospital Experience

Another interesting factor identified as a facilitating patient characteristic was prior hospital experience. Three patients specifically mentioned that knowing the hospital system and routine was helpful because they then knew what to expect. These patients believed someone unfamiliar with a hospital's routine and environment would
be more likely to be dissatisfied with nursing care and the hospital experience in general.

Facilitating and inhibiting characteristics of the patient are listed in Appendix E under the category heading of "The Patient -- Positive Attributes" and "The Patient -- Negative Attributes." Also, a diagram visually displaying the patient's positive and negative characteristics is presented in Appendix F.

**Relationship Factors**

A strong, recurrent theme concerning nurse-patient relationships became apparent as content analysis of interview transcripts progressed. Repeated references, direct and indirect, were made by both nurse and patient participants about the importance of their relationship. This phenomena of relationship development and maintenance was mentioned interchangeably with nurse empathy, patient satisfaction, and also was mentioned in reference to nurse satisfaction.

Patients and nurses described characteristics of individuals who were able to establish and maintain relationships with others. These characteristics were remarkably similar to those identified as nurse empathy characteristics. However, a relationship implies a mutuality. The patient's willingness to be involved in a relationship with the nurse was as important as the nurse's willingness to be involved with the patient. Participants believed a
mutual openness must exist for the establishment and growth of a relationship.

It is beyond the scope of this study to begin to examine the ramifications of the findings about nurse-patient relationships; yet this information is important in context with nurse empathy and patient satisfaction. A brief description of major findings will be presented with appropriate participant quotes, and the reader is referred to Appendix E for a listing of the characteristics describing nurse-patient relationships. A graphic representation of relationship facilitators and inhibitors may be found in Appendix F. Additionally, a diagram has been developed to incorporate the relationship factor into the interactions of nurse empathy and patient satisfaction by outlining how the nurse-patient relationship impacts nurse empathy and patient satisfaction (Appendix F).

Facilitators

One young nurse connected the concepts of nurse empathy, relationship development and balance in this quote.

N001: (the role of empathy in nursing) ... can really facilitate and open a relationship with a patient. You can be empathetic ... (while still) saving part of yourself for yourself.

Two nurses had these observations on the importance of relationships to their personal satisfaction.

N002: The reason I moved to (this city) was to go to law school, but I put it off for a while and
worked at (this home). And it was working there that completely changed my mind about my career, and made me realize because of these kinds of relationships (I developed) with these people that I had never, ever considered nursing before that, and would have thought it was too traditionally sex-stereotyped a profession for me. But I discovered about myself this kind of bonding with the clients and made ... a career change.

N017: I think that it's good for the patient, but it's also good for the nurse to develop the bond with that patient and family.

Two nurses commented on the mutual nature of nurse-patient relationships, identifying that these relationships are special in a way few other relationships are and that mutual feedback is critical for relationship development and maintenance.

N017: Patients hopefully, in some sense, feel they need you, whereas in a lot of other relationships, it's not based on need, it's based more on maybe a mutual agreement, or likes or dislikes, or some other commonality between them.

N008: Everything just kind of clicked into place. She developed good relationships with all of us, and she let us know how she felt. And we would give her feedback and we would respond to her appropriately. And I think everything worked out really well with her and she let us help her.

Nurses and patients agreed that primary nursing was far superior to team nursing for facilitating relationship development. In the following quote, this nurse connects the concepts of primary nursing, relationships, empathy, and nurse satisfaction. She described how she believes she would feel if she had to work in a team-nursing environment, as did many of her friends who were employed at other facilities.
NO15: If I was working in team nursing, I think I would be burned out really readily. Because I wouldn't feel like I was doing or giving what I want to give, and why I went into nursing. But, because (we do) primary nursing here and being able to establish relationships with people over a long period of time and really making a difference; and using empathy to really make a difference, I find it so much more satisfying.

One nurse, who said she identified with the families of terminally ill patients more readily than patients, had this observation about nurse-family relationships.

NO16: When people walk away when you've taken care of the family for the first and last time, or that patient, and the family leaves hugging you, you think, "WOW!" I know that it's just part of the whole emotional experience, but it also conveys that they connected with you in those last hours and it was important to them.

One patient, with multiple health problems and admissions over her lifetime, had this observation about the importance of nurse-patient relationships. She connected the concepts of relationship development, patient satisfaction, and nurse satisfaction. This was her response to the question "What would you tell nurses is the most important thing for them to do?"

PO09: I think it's more relationship and I think the patient will get better faster, and the nurse would understand them and what they need, better. And everybody's happy.

Another nurse articulated the individual nature of relationships.

NO08: We've had patients who've had cancer and very bad prognosis and they can let us in and let us know exactly how they're feeling. It's not necessarily what we do, you can do the exact same thing in two different rooms and get two different
responses from them.

One family believed that the environment on one particular unit of the study facility was conducive to relationship formation because they saw positive relationships around them.

N014: (This family) said, "You can just get a feeling for a hospital or for a floor." Patients even listen to the dialogue in the hallway. And they say, "Everyone here gets along so well! They're all friendly in the hall, helping each other. And in other hospitals, they fight and you hear them yelling, and they're angry and they're talking about this one, talking about that one." I've had patients say that it's just a nice atmosphere.

A complete listing of relationships facilitators is listed in Appendix E, and again in Appendix F, in a graphic illustration entitled "The patient: Facilitating and inhibiting descriptors." Many of the terms should be familiar to the reader as they were also used in answers to the previous questions in this chapter.

Inhibitors

Those factors identified by participants as relationship inhibitors are, in essence, repetitions of those factors and descriptors previously listed under nurse empathy inhibitors (See Appendices H and I). The predominant factor identified as a barrier to relationships was intense emotion of any kind that blocked the ability to let another person in. This lack of receptivity was frustrating to nurses, who recounted some instances of
inability to establish relationships despite their best efforts.

Intense emotions, such as anger, anxiety, or fear, were identified by nurse participants as being inhibitors to the development of a relationship.

N002: (This one patient) turned out to be an unbelievably anxious woman; it was really hard to get anywhere around that. Even trying a lot of different strategies, it was pretty difficult.

N008: I think she was just angry because of the disease itself and she just didn't want to let anyone in.

N005: There are times when no matter what you do, a person just cannot perceive it (empathy), just because their anxiety is so out of control.

Some nurses believed the most difficult patients to establish a constructive relationship with were those for whom loss of control was an insurmountable issue.

N005: The people who I've struggled with the most are the people who are used to being in control. And that's a way of coping for them. And not only people used to being in control, but people who are used to being very self-reliant. They protect themselves from being dependent on anyone. And to allow someone to be with you, to get to a place where they feel that you're empathetic means that you have let yourself get vulnerable to that. And for those for whom that is such a big problem, that (vulnerability) creates pain and anxiety in itself.... The situation may be so out of control for them that no matter what you do, they still feel a sense of helplessness, and a sense of, "No one's helping me and I want someone to take this away from me." And sometimes you can't, unfortunately, take it away from them. And because you can't, then they feel disappointed, especially when they say, "You aren't empathetic or you would cure the problem."

Nurses also identified that a patient's family history and
patterns of coping were significant factors in their ability to establish relationships. As the family is our basis for forming relationships, it is understandable that the patient with poor family relationships would find it difficult to establish nurse-patient relationships.

N002: I'm not sure that he's inherently totally reachable. He's been this way with his own family all his life and he's being this way with us now. I think he had a pretty troubled life and he really didn't learn how to interact with people. I think you have to have some ability to make relationships with people in order to make these relationships work in the hospital.

One nurse recognized the need for holistic nursing.

N009: Sometimes it seems like your primary focus is on the patient but, the patient always comes with baggage, whether it be a family or a boyfriend or a husband or a wife or kids or whatever.

In some cases, the personalities and styles of the nurse and patient inhibited relationship formation.

N002: It's his depression and negativity I find hard to find a foothold in and another nurse who does much better with him has a style about her where she actually treats him a little more like a child, like I say, this is an adult and I treat him like an adult.

A complete list of relationship inhibitors is presented in Appendix E. Again, many of the terms will be familiar to the reader as they have been used previously to describe nurse empathy and patient satisfaction inhibitors.

The similarities between the descriptors used by participants to describe nurse empathy, patient satisfaction, and relationship facilitators may be conceptual-
ized by three overlapping circles. Each circle represents one of the three concepts: nurse empathy, patient satisfaction, or relationship facilitators. Each circle has common descriptors appearing in the appropriate section. This diagram is presented in Appendix H. Another diagram illustrating the nurse-patient relationship and interaction within the hospital environment as discussed above is presented Appendix F.

Nurse Satisfaction

A truly unexpected and delightful result of this study was the fact that content analysis revealed the empathic nurse is more likely to be satisfied with nursing as a career choice. Both patients and nurses indicated that the empathic nurse usually had a positive attitude and enjoyed her work. Conversely, participants agreed that the unempathic nurse was not usually satisfied with nursing as a career.

Balance

The most prominent characteristic of the nurse felt to facilitate satisfaction with nursing was an ability to balance personal and professional involvement with others. The reader will recognize this category from earlier discussions.

Nurses and patients described young nurses who were "enmeshed," or overinvolved, and experienced burnout.
Many nurse participants in this study were able to describe instances where they had become too involved and had experienced burnout as a result. The nurses described a phenomenon the researcher termed "balance," which has been mentioned before in this chapter in context with nurse empathy. Briefly, balance is the ability to be involved in a dynamic manner with the patient and family. The nurse controls this involvement, and becomes more or less involved as required by the nurse to maintain professional effectiveness and meet both patient and nurse needs.

Nurses agreed that maintaining balance required a certain level of self-knowledge and self-awareness. Nurses described peers who become overinvolved with patients as meeting their own needs, rather than the needs of the patients. Administrators also described these nurses and instances of overinvolvement.

At the other end of the spectrum, the nurse who was "disengaged" or distant and cold, was described as not being satisfied with nursing as a profession and was thought to be negative and unhappy in general. Participants described the evolution of a young nurse, enmeshed with patients and others, getting hurt, and then becoming a disengaged nurse out of self-preservation. This nurse was described as unhappy and not satisfied with nursing. She had not learned how to balance. One nurse, identified
earlier as an outlier, identified how she alternates between burnout and involvement. This was the outlying nurse who did not seem to learn from her experiences, and this quote further illustrates the point.

NO16: I have had periods where I felt burned out and periods where I feel energized and it's very cyclical.

Another nurse quote identifies a nurse who has learned how to balance her involvement for her own self-preservation.

NO11: You have to show somebody that you're a real person, that you have feelings. But without setting yourself up to be smashed in the process or giving so much that you're drained all the time also. I get involved, but I've also learned not to get as involved. (How do you do that?) You don't tell as much about yourself maybe. It's hard to say. I think there comes a point when you just learn, you just know that you're getting too far, and maybe once you've gone too far is when you realized it.

Facilitators

The following quotes illustrate nurses' feelings about nursing and empathy and the importance of empathy in their professional practice. The first quote identified the concepts of balance and nurse satisfaction.

NO01: You can do it and save yourself at the same time. You can get satisfaction from giving those kinds of things with patients. That's where I get my satisfaction, by really feeling like I made a difference in someone's care, or made a difference in their day at the hospital.

These quotes identify the connection nurses say exists between nurse empathy and nurse satisfaction.

NO02: When I distill out what's really special or what's really different about what I do for people
that makes me love nursing, it's usually got to do with the kind of relationship that I've developed with people. And to me, that's sort of the essence of what I do as a nurse that really matters.

N005: I think about empathy and I think, to me that's the joy of nursing. That's where I get all of my satisfaction. To me, that's the exciting part about where I learn so much about life, about myself and about other people. And it just opens up so many doors to me. So it's worth the effort to develop, it's worth the effort to try to be there -- to allow the patients to teach us actually what it is all about.

N001: I would not stay in nursing if I didn't like caring for people, or didn't like being involved with them, and knowing about things that hurt them, or make them cry. I really think that it's a gift. Not everyone can be a nurse.

One nurse with over 10 years of experience identified why her particular specialty area was so satisfying for her.

N005: The greatest pleasure I have is when people say, "why do you do oncology nursing?" For me, it's that people are more up front and more honest and real about what's going on for them and what's important all of a sudden. They lose all of that excess baggage and also start dealing with the crux of what's going on and what's important to them; and you can learn so much from them if you just take the time to allow it to happen.

These quotes illustrate the value of patient and family appreciation to the nurse, and its effect on the nurse's job satisfaction.

N001: It just knocks me out how much of an impact we have on patients and their families. I've gotten letters from families; they mail gifts. I didn't realize how important we were to people until I had experiences like that.

N004: I think that you definitely need it (empathy) to feel kind of satisfied in what you do, cause there are lots of times you go home, you've had a terrible day. But then, you think that this person really liked when you take care
of them and they really appreciate what you do when you're here. I don't mean to sound conceited or anything, but sometimes you'll overhear a family member say to somebody, outside in the hall, "She's so great with my wife. She's so good to her, and she takes really good care of her," even though ... I'm pulling my hair out cause I have a stress level up to here; then when you hear that, you know at least all this effort, these people appreciate it. It's nice to hear. I think you need to feel like you know you've done something good for people and you can feel for them because, if you don't, if you separate the two, then I don't think it will be as satisfying work.

N011: There's a definite correlation (between nurse empathy and patient satisfaction). That's what makes you enjoy giving your care, I think. If people weren't satisfied by it, if there wasn't some sort of satisfaction, there would be no positive reinforcement to do it -- or to try to do it.

One nurse described how privileged she felt to be present with a patient when he died. In the telling of this story, which has been shortened here, both the nurse and researcher were moved to tears. This experience was an important personal event for this nurse and was an example of how being a nurse was very satisfying to her.

N011: I didn't know him (he had been comatose since admission), but I felt over the course of the month of taking care of him every day, that I knew him through the family. I really felt that he responded to me. (One day), I knew he was going to die. I knew. I can't even describe it. I just sat there, alone with him, and I talked to him. I really -- felt -- that he knew I was there. And, this sounds weird, but there was someone else in that room with us, I know there was. I felt like -- I watched his spirit leave his body, I really did, and that is totally off the wall. I'd have to say it was a ... spiritual experience, in a way, and I really felt -- special that I was there. It was unbelievable.
Inhibitors

Nurses were also able to readily identify those things that resulted in their being dissatisfied with nursing, and were characteristics of the nurse who was unhappy in the profession. It was interesting to note that many of the characteristics used to describe the dissatisfied nurse were the same ones used to describe the unempathic nurse. Participants were also able to identify the enmeshed or disengaged nurse. The following quotes illustrate various aspects of the dissatisfied nurse.

N009: It's difficult to always spend time with patients because you really have to sacrifice a piece of yourself. Some people aren't willing to do that or can't do that or have done it for too long.

P008: If you're the type of person who really gets into people -- let things get to you -- it can burn you out to a point where you're not as bubbly or whatever you were when you first started the job. Not that you don't care about people, some people are able to shake off and don't let things get to them to a point where it just aggravates them. Some people don't know how to leave it alone (leave work at work) once you walk out. You don't take those feelings with you to a point that you get a overload. You get really stressed out. And that doesn't say that you're a bad nurse or a bad person, no. It's just some people know how not to let things get to them.

Being robot-like or mechanical in function was identified as a characteristic of the unsatisfied nurse.

N008: But I have worked with some people that aren't (empathic) and they don't like their job very much. I just think that people would hate their job if they couldn't really be there and be with patients, and not be so mechanical and be like a robot running around and doing what they
had to do. I think that it's a major role, it plays a major part in our profession.

N014: A girlfriend mother's (who is a nurse) said, "All you need is a roll of toilet paper to be a nurse." Well, obviously she doesn't get much satisfaction out of her job and she's doing it because it's a paycheck. And that's her profession by trade. She's a nurse ... like someone's a mechanic.

This patient, with three nurses in his immediate family, observed that compassion was a necessary ingredient for nursing satisfaction and a long nursing career.

P017: I don't think people or nurses can be anything but compassionate, and last in the profession. I don't think they'd last 2 years in it because they'd make themselves miserable, as well as all the people around them. I think they're probably the ones that get out early on.

Finally, one patient observed how important balance was for a nurse to remain satisfied in her profession.

P001: (My advice is to) be nice with everybody, but don't get that close where you get hurt. Just do the best of your ability to make the patient at ease and help them as best you can. But it bothers me that if a nurse got close to every person, she'd be wringing her heart out every week. You got to do your job, you can still be close to them, but you can't get that close.

Summary

Nurse satisfaction with nursing as a profession seemed closely aligned with other concepts studied. A complete list of facilitating and inhibiting factors for nurse satisfaction are listed in Appendix E and are presented graphically in Appendix F. The relationship between nurse empathy, patient satisfaction, and nurse satisfaction is
diagrammed in Appendix I, with three overlapping circles illustrating the connections between the three concepts. In Appendix F, nurse outcome is in the schematic representation of study findings that are creating a conceptual perspective of nurse empathy and patient satisfaction.
CHAPTER IV

CONCLUSIONS, IMPLICATIONS, AND
RECOMMENDATIONS FOR FURTHER
STUDY

In this chapter, conclusions from the findings, implications for nursing practice, education, and administration, limitations of the study, and recommendations for future study will be presented. A final conceptual framework will be presented in Figure 2. The final conceptual perspective of nurse empathy and patient satisfaction is presented in Appendix F.

Conclusions

Conclusions from the findings of this study are presented in this section. Conclusions include the categories of "nurse empathy and patient satisfaction," "relationships," and "nurse satisfaction."

**Nurse Empathy and Patient Satisfaction**

The intent and most important goal of this study was to identify a relationship between nurse empathy and patient satisfaction with nursing care. Results of qualitative data clearly indicate a positive relationship between these two concepts. Similar or identical descriptors were
used by nurse and patient participants to describe characteristics of empathic nurses and nurses whose care was satisfying to patients.

When discussing the attributes of the empathic nurse, participants described a sensitive individual who had a level of maturity and self-awareness that allowed focusing on the patient's issues and needs. Attributes of the nurse as a person seemed to be more important to the manifestation of nurse empathy than were the attributes of the nurse as a professional. Nurses cited personal experiences as being particularly helpful in their development of self-awareness and sensitivity to others. However, getting the most out of these experiences required some introspection and an analysis of the experience by the nurse to understand the value and meaning of the experience.

Nurses saw the profession of nursing as one way in which to operationalize their philosophies of life. Making a difference in someone's life or hospitalization and helping others was a focus of participant nurses' philosophies of life and of nursing. The similarities of these philosophies helped the nurse find satisfaction with nursing as a career.

Both nurse and patient attitudes were identified as being important to nurse empathy and patient satisfaction. Nurses who were empathic and patients who were satisfied
with nursing care were typified as being positive people who tried to see the positive side of adverse situations. Nurses and patients would remark how impressed they were with each other. Nurses were amazed at how patients handled their hospitalizations and adverse life experiences and felt they grew, personally and professionally, from their close association with patients and their families. Patients continually remarked how hard working and dedicated their nurses were and how they had special admiration for people who chose nursing as a career.

**Relationships**

Repeated reference was made to the relationships that developed between nurses and patients. These relationships held special meaning and value for both nurses and patients. Nurses found the most rewarding component of their work was relationships developed with patients and the patients' families. Patients described these relationships with their nurses as what made their hospitalization bearable and what they most fondly recalled after discharge.

Nurses and families also developed relationships that were valuable to the nurses. As families were not included in this study, assumptions cannot be made about the value and importance of the nurse-family relationship to family members. However, if the importance of the relationship to the patient is any indication, families most
likely also find these relationships valuable.

**Nurse Satisfaction**

A serendipitous finding of this study was the correlation between nurses who practice nursing in an empathic manner and nurses' satisfaction with nursing as a career. Participants characterized satisfied and energized nurses as those who embodied the same characteristics as empathic nurses. Both nurse and patient participants described nurses who met the criteria of an unempathic nurse and who were unhappy with nursing as a career. These nurses were also described as being unhappy with themselves.

Another interesting correlation was apparent between relationship formation and nurse satisfaction. It became clear that nurses who were unable or unwilling to form and maintain relationships with others manifested behaviors that led others to believe they were unhappy with nursing as a career and with themselves, as well.

**Poststudy Conceptual Framework**

Upon completion of data analysis and interpretation of results, additions and modifications were made to the original conceptual framework. The revised conceptual framework does not reflect the quantitative survey instruments administered, as results from these surveys were inconclusive. While much more was known about both nurse empathy and patient satisfaction at the conclusion of this
study, there is still much to learn, and this is reflected in the conceptual framework by "unknown factors." The revised conceptual framework is presented in Figure 2.

A New Perspective

Upon completion of data analysis, the researcher formulated a conceptual perspective of the interaction and relationship between nurse empathy and patient satisfaction. This conceptual perspective visually facilitates understanding the major concepts under investigation. This conceptual perspective, Figure 3, represents a combination of figures introduced and discussed in Chapter III and diagrammed in Appendix F. This figure chronicles the nurse and patient prior to, during, and after their hospital encounter. The reader should be familiar with the components of each circle and the large square from information presented and discussed earlier.

Implications for Nursing

This results from this study have significant implications for nurses and the profession of nursing. Implications for nursing practice, education, and administration will be addressed individually. The suggestions and observations made are by no means exhaustive, but are intended to initiate thoughtful discussion about how the results from this study may be operationalized into nurse
Figure 2. Poststudy conceptual framework.
Figure 3. Conceptual perspective of the nurse, empathy, and patient satisfaction.
practice, education, and administration.

**Practice**

Practicing nurses will find the results of this study particularly helpful because the information speaks eloquently of the need for developing and maintaining nurse-patient relationships with the aid of nurse empathy. Fostering the development of nurse empathy and having this result in patient satisfaction with nursing care is powerful information that should be utilized to improve patient experiences and the increase the impact of nursing within a hospital setting.

While many nurses believe remaining distant and uninvolved is the answer to avoiding burnout, these nurses described establishment and maintenance of balanced involvement as important to their continued energy and satisfaction with nursing. This balanced involvement with patients and families was a skill that developed over time, and was important to nurses and patients. Nurses agreed that not being involved with patients and families was not satisfying for them professionally and personally, and that nurses unable to become involved with patients and families were more likely to burnout than those who were involved.

Adequate staff support for nurses is needed on the unit level to help individual nurses grow and develop their relationships skills and develop the self-awareness
necessary for balanced nurse-patient relationships. Providing and fostering an environment where relationships are valued and appropriate involvement is encouraged may help retain nurses and prevent burnout for nurses who are direct care providers. The results of this study offer one perspective on how to maintain energized and effective nurses in the profession.

In facilities where a lack of funding equates to no organized staff support, the researcher believes that with special inservice education and experiential seminars, the staff nurses and managers would be able to begin to create an environment conducive to the development of empathic communication and mutual support. Nurses identified support from and discussions with their peers as being very important in helping them to maintain a healthy perspective on what was important, and especially in dealing with difficult patients and families. In the researcher's personal experience with a number of inpatient hospital units, each nursing staff within a unit develops a composite personality. Using this composite personality as a base, the wise administrator and motivated staff could, with some outside assistance, create a supportive and growth-producing environment where both nurses and patients could experience the satisfaction described by participants of this study.
Education

Using the results from this study, nursing educators may begin to encourage appropriate involvement between nursing students and their patients at an early stage in the student's development. Assisting the student to develop the requisite self-knowledge to balance their involvement with patients may allow future nurse to become energized by caregiving, rather than burned out. Students who are afraid of getting close to patients for fear of getting hurt need to be encouraged and guided in examining these fears and develop coping strategies for these situations when they occur. Nursing educators can have a great impact on the future of nursing if they are able to assist their students develop this art.

It is uncertain which educational strategy would best facilitate the development of empathy. As nurse participants observed, one could teach the theory and motions of empathy, but actual development of the affective component is more difficult, as well as being the goal of empathy development. The nurse participant who identified a need to develop empathy and was a self-taught empathizer, taught herself this skill through careful observation and modeling of other nurses who she believed to have this skill. This approach, modeling, would appear to be effective for some individuals. Further investigation is needed to determine the most effective method of actually
developing empathy, not simply teaching it.

If students are to be guided in the development of empathic skills, the faculty of schools of nursing must be well-versed in this skill, as well. To effectively implement a strand of empathic communication throughout a nursing curriculum, faculty development would have to be addressed. Results from studies such as this should assist faculty in appreciating the value of empathic communication between nurses and patients. Additionally, the information that nurse administrators in this study identified empathic communication with their staff nurses as a key factor in modeling and facilitating staff empathy with patients should assist nursing faculty in understanding the need for them to empathically communicate, understand, and "be there" for nursing students. The key to successful implementation of an empathy component in a school of nursing would be obtaining the support of the faculty clinically involved with nursing students.

Another issue that inevitably is examined periodically, and is pertinent at this point, is the issue of admitting only certain types of people into nursing programs. Should students who score at a certain level on the LEP or the BLRI be admitted to nursing programs and others declined enrollment? In light of the current nursing shortage and declining enrollments in higher education due to the declining numbers of college-age stu-
dents, selective admission to schools of nursing may be a moot point. However, information obtained through nurse participants in this study would seem to indicate that individuals may develop empathy as a need is seen for it, even if they are not especially empathic initially. The challenge to schools of nursing is to create an environment and expectation that encourages students to grow personally and professionally throughout their education.

As discussed, Holt-Ashley (1985) conducted empathy training workshops, as did Kalisch (1971a,b). While empathy levels were recorded as increasing following empathy training, as has been discussed, the terms "measurement" and "empathy" may be mutually exclusive. It remains unclear if empathy measures are actually measuring what they purport to measure. Empathy "measurements" may not be the best evaluators of nurse empathy. Perhaps patient satisfaction measures would be a more valid evaluation of nurse empathy development.

**Administration**

The establishment of a care environment where nurse empathy and patient satisfaction can occur is within the domain of the nurse and hospital administrator. The study facility's key leaders repeatedly asserted that the hospital's long-standing tradition of primary nursing and a supportive nursing milieu were, in part, responsible for the kind of quality nursing care for which they were
nationally known. Nurse managers believed their nurses were able to apply empathy in patient care situations, in part, because nurses had effective and empathic relationships with their nurse managers. In effect, the nurse manager was empathically aware of the needs of the nursing staff and attributed this supportive environment and relationship as critical to the nurse's ability to provide empathic care to patients. The results of this study speak to the need for caring, responsive, and supportive nursing managers, to facilitate nurse and patient satisfaction and well-being. Taking a punitive or disciplinary approach to managing nursing and caregiving situations does not foster development of nurse or patient satisfaction. Nurse managers need to model for their staff those attributes they wish their staff to emulate.

Assessing the costs of incorporating staff support, counseling, and generous nurse-patient ratios to facilitate relationships in a facility is difficult, speculative at best, and beyond the scope of this study. Establishing a supportive milieu for nurses and patients may be costly in the short-term analysis, but may save the facility recruitment, orientation, and retention funds at a later date. Based upon the information obtained in this study, nurses who practice nursing in a setting such as that described above truly enjoy nursing and feel personally and professionally fulfilled. Logically, these nurses
would not leave the facility unless circumstances forced them to. The monies spent on supporting and assisting these nurses in their professional development would be an investment not only in the nurse, but in the patient and that patient’s satisfaction with the nursing care and hospital experience in general.

Limitations of the Study

The researcher was under time constraints in that she spent a limited time (2 months) at the study site. A longer period of time at the study site would have allowed for the attainment of more nurse-patient pairs. Additionally, financial constraints were limiting. Financial limitations directly affected time limitations, as the researcher could not realistically spend any more time at the study site.

There were also time constraints on the participants. Some nurses were interviewed on their home units before or after work and, thus, had to bring the interview to a close after 1 hour in order to leave for work or home. Some patients were not feeling well enough to hold lengthy conversations or received unexpected calls and interruptions. Key leaders often had very full schedules and had numerous phone or other interruptions. These limitations were countered by the sensitivity of the researcher in knowing when to bring an interview to a close or scheduling another interview, as well as in scheduling the inter-
views at a convenient time for nurses and key leaders and waiting until the patients were home and had recuperated for a few days.

Inadequate questions asked of the participants during the interviews may have resulted in the researcher failing to elicit the most significant information. Any study using open-ended or semistructured interview schedules may suffer from this limitation. This limitation was countered through the careful formulation of questions by the researcher with the assistant of the researcher's committee members, pilot-testing the interview guide, by using open-ended questions, and by allowing subjects to digress as seemed appropriate to the topic.

While nurse participants readily identified with the researcher as a nurse, patient participants seemed more hesitant to discuss negative experiences related to nursing care in the hospital. Patient participants may have been reluctant to share information about nurses with another nurse. Participants were assured that the researcher was not affiliated with the study facility in any way. Every effort was made to not identify the researcher as a nurse to patients; however, most patients guessed the researcher was a nurse and, if asked, this was not denied. This may have affected the results by producing less data or less accurate data from patient participants.
Other constraints and limitations included unavailable nurses (ill or on vacation) and patients who did not consent to participate in the study. Participants indicated they were motivated by a desire to help the researcher, nurses, and patients. Individuals who were approached and declined to participate may not have felt this desire to help others and may have had different perspectives on nurse-patient relationships. It is uncertain what kind of information these patients would have provided and how this information would have affected the results.

The preconceived sample of nominated nurses and their patients was also a limitation. The purpose of this study was to obtain an optimal sample from an optimal facility. Including nurses who were not nominated and their patients in the sample would have provided a different perspective and valuable insights into the topic under investigation.

Credibility and Dependability of Results

The issues of generating reliable and valid results from qualitative research were addressed by Lincoln and Guba (1985) and Sandelowski (1986). It is their premise that judging a qualitative study with the traditional, logical positivist values of reliability and validity is not possible, or appropriate. Reliability and validity
are issues most closely associated with quantitative research and other issues are more appropriate in evaluating qualitative research. These more relevant issues are credibility, transferability, dependability, and confirmability.

Credibility is the degree to which the researcher is able to accurately reconstruct the multiple realities of the participants. Credibility is the naturalistic researcher's equivalent to "internal validity." One method of establishing credibility is checking out the findings with the participants, who are the best evaluators of credibility. Upon completion of data analysis, 3 nurse participants and 1 patient participant were contacted for feedback about the results of this study. All participants concurred with the study's major findings and did not offer any additional, or contrary, insights into the subject. Two nurses had experienced alterations in health since their involvement in this study. These experiences had allowed them to gain more insight into patient experiences, and they elaborated upon this newly gained insight. Their personal experiences again resulted in personal and professional growth, a consistent finding in this study.

Another method to ensure credibility is through triangulation of sources and methods. In this case study, the researcher gathered information in a number of ways
from multiple sources. Interviewing nurses, patients, and key leaders offered multiple perspectives on the study topic. As data collection progressed, semistructured interview guides were amended and expanded to encompass new or different information that emerged from the interviews. Triangulation through multiple methods of data gathering was accomplished through the administration and collection of quantitative survey instruments from nurse and patient participants. An additional method of data gathering was the collection of various hospital policies, procedures, publications, and advertisements that related to the study topic. All of these sources confirmed the institutional importance of the nurse-patient relationship.

Transferability of findings is that ability to transfer the results of one study to another situation. Transferability is the naturalistic researcher's equivalent of "external validity." While transferring the results of this study to another setting is not inherently possible, it is the responsibility of the researcher to adequately describe the phenomenon and its context in such a way that others may determine the value and transferability of the findings. Feedback obtained from the researcher's peers who are employed in other settings in various states and facilities, and who have numerous collective years of nursing experience, have indicated
that the results of this study "make sense" and "ring true." It is hoped that this study will be repeated in other settings, either by the researcher or others. In this way, the transferability of the results will be better known.

Findings are considered dependable if they are credible. One means of establishing this qualitative form of "reliability" is through an inquiry audit. The researcher's committee chair served in this capacity as data analysis progressed, reviewing interpretation of data with the researcher. Another form of establishing dependability is to perform an interrater reliability audit. This was accomplished by having an uninvolved party read and code one participant interview using the developed code book. An approximately 80% congruence occurred between the researcher-coded and interrater-coded interview.

Confirmability of the findings is the qualitative equivalent of "objectivity." Lincoln and Guba (1985) asserted that the conventional concept of objectivity is unproductive in naturalistic inquiry, as the researcher is by necessity involved and a part of the research process. In this study, it is true that the researcher had an interest in the subject matter prior to conducting the study and this interest prompted the study. The researcher made every attempt to bracket herself during
interviews and allow for the investigation of new, contrary information. For example, the first patient participant informed the researcher that empathy, in her opinion, was a gift and not teachable. This information contradicted the researcher's hope that empathy was teachable, but also prompted the researcher to develop more probes in the interview tool around this question to further investigate the concept. The majority of informants repeatedly affirmed the major findings of this study, mainly that nurse empathy was important to patient satisfaction, nurse satisfaction, and relationship formation. The repetition of these themes by many participants offered a confirmation that the themes and premises of the study results were actually real and not researcher-induced.

This study, like many others, is not perfect and questions may be raised addressing the study's credibility and transferability to other practice settings. However, these limitations do not obscure the fact that this study has initiated a line of research about nurse empathy and patient satisfaction and established the importance of nurse-patient relationships to nurses and patients. This study has also established a base of inquiry for the concept of nurse satisfaction with nursing as a career. The information obtained from this study will facilitate the development of future research in nurse empathy, patient
Recommendations for Further Study

As in any study, many more questions arose during data collection, analysis, and after the completion of data analysis than were proposed or foreseen at the inception of this study. While there are many interesting topics within this study that merit further investigation, five major areas of study are identified here. These five areas are nurse empathy, patient satisfaction, environment, relationships, and nurse satisfaction.

Nurse Empathy

The first area, that of nurse empathy, has many unknown subtle nuances that have been brought to light with this study. With participants' responses conflicting on the teachability and development of empathy, it would be interesting to know more about how empathy could best be "taught" to nursing students and nurses. Allowing for participants' assertion that empathy cannot be taught but must be modeled, more should be known about the optimal methods and times for this modeling to occur. Negative or conflicting cases would contribute to knowing more about empathy. This study focused on the ideal situation; highly empathic nurses and their patients in a setting where relationships are valued and supported. Repeating this study with nurses who were identified by managers as being
unempathic and their patients would add a new dimension to this study and allow for a better understanding of the phenomena.

**Patient Satisfaction**

Concerning patient satisfaction, it became apparent during content analysis that there are many more variables influencing a patient's satisfaction with the hospital experience than nursing care. Patient participants alluded to a number of them, such as negative medical outcomes and experiences with physicians. However, due to the specific nature of this study, elaboration on these themes was not encouraged. Taped interviews proved to be a helpful data gathering tool for patient satisfaction as patients were free to discuss any and all memorable hospital experiences. It would be helpful to know more about the experiences that patients find helpful or distressful during their hospitalizations.

**Environment**

More needs to be known about the environment in which the nurse provides care to the patient. Nurse, patient, and key leader participants all agreed that the study facility's long-standing tradition of support to nurses, a caring environment and primary nursing fostered development of nurse-patient relationships and nurse empathy. Repeating this study in a different facility and care
environment would undoubtedly yield results that would help nurses and hospital administrators understand the impact of the environment on nurse empathy and patient satisfaction.

**Relationships**

More needs to be known about the nurse-patient relationship and how this relationship affects nurses, patients, families, and others. Repeated references by both nurses and patients about the importance of the relationship that developed between them brought to the fore the general lack of knowledge about this relationship. Results from this study indicated that relationship formation was a skill nurses developed from earlier relationships with families and others. It is important to know if it is possible to facilitate an adult nurse's ability to develop and maintain relationships with others. It would also be helpful to know if there is an optimal level of involvement between nurses and patients and how nursing educators can best teach nurses to establish and maintain relationships with patients that will not only meet patient needs, but meet the nurse's needs, as well.

**Nurse Satisfaction**

A fertile area for further research is that of nurse satisfaction. Nurses and patients in this study characterized the satisfied nurse, the nurse who found her philoso-
phy of life and philosophy of nursing to be remarkably congruent. The results of this study identify the need for more information about nurse satisfaction and dissatisfaction and how to facilitate the development of a satisfied nurse. Of interest for future research would be creating an empathy-development program for staff nurses and measuring their job satisfaction before and after the program, as well as patient satisfaction before and after the program. There is evidence in this study that indicates the nurse's personality and attitude have a great deal of impact on this area. However, it may be possible to positively influence nurses in a manner that would result in their development into self-aware and satisfied nurses who discover their profession fulfills very personal needs and goals. Another area of critical importance is the investigation of the concept of balance and burnout and the critical incident when this is likely to occur. Knowing how to identify who is most likely to experience burnout, when will it occur, and how the nurse manager and/or nurse peers can recognize and intervene with the overinvolved nurse might prevent some nurses from leaving the profession or staying and causing dissatisfaction in themselves and their patients. These and other questions remain to be investigated in the future.
Summary

Practicing nursing in an empathic manner, establishing relationships with patients and their families, and knowing that you have made a difference in someone's life were very important outcomes of nursing for the nurse participants studied. Prior to this study, the researcher only knew that practicing the art of nursing was personally valuable and important. Now it is known that practicing nursing in this manner is valuable to other nurses, as well. More importantly, practicing nursing in this manner also makes a difference for patients. The power inherent in this information should not be ignored or denied.

Nurses need to find a balance between the science and art of nursing. Nurses need to know the science and practice the art of nursing -- not only for their patient's sake, but for their own. This closing quote, from an especially insightful nurse, sums up the essence of this study's importance.

NO05: I think about empathy, and I think, to me, that's the joy of nursing. That's where I get all of my satisfaction. To me, that's the exciting part about where I learn so much about life, about myself and about other people. It just opens up so many doors to me. So, it's worth the effort to develop. It's worth the effort to try to "be there," and to allow the patients to teach us actually what it is all about.
APPENDIX A

INVITATION TO PARTICIPATE IN A STUDY
Dear Nurse,

My name is Karen Brown, and I am a graduate student at the University of Utah College of Nursing. I am conducting my dissertation research at XXXXXXXXXXXX Hospital. My topic of interest is the nurse-patient relationship. I am investigating the relationship between nurse empathy and patient satisfaction with nursing care. Your Nurse Manager suggested I contact you as she/he thought you would be interested in participating in this study.

I would like to interview you and ask you to complete two brief surveys and a demographic information sheet in the near future. The purpose of the interview is to discuss your thoughts on nurse empathy and patient satisfaction. The interview will last approximately 1 hour, and will be scheduled at a time and place of your choice.

This study has been approved by the XXXXXXXXXXXX Nursing Research Review Board and Committee on Clinical Investigations, and the University of Utah's Institutional Review Board. There is no financial remuneration for your participation in this study and your participation is entirely voluntary. You may withdraw from the study at any time. Your participation or refusal to participate in this study will not affect your employment status at XXXXXXXXXX in any way.

Benefits to you from your participation in this study include sharing your philosophy of nursing and insights into nurse empathy and patient satisfaction with the researcher and having the opportunity to share your insights and philosophy with a wide nursing audience through publication of these data. The potential risk to you for participation in this study includes being inadvertently identified through the topics and anecdotes discussed through the interview. The possibility of this will be minimized in the following ways:

1. Your patient care unit, and any names of patients or co-workers you may mention will be changed to protect anonymity in reporting the data.

2. Any verbatim quotes will be used in summary presentation of the data only.

3. All personal data will be kept confidential. Interview transcriptions will be numerically coded, and upon completion of the study, the key to the coding will be destroyed.
A summary of the study will be sent to the Directors of Nursing and the Associate Vice President of Nursing at XXXXX.

I am looking forward to meeting you and getting to know your thoughts on the nurse-patient relationship. If you have any questions concerning this study or your participation in it, please do not hesitate to call and talk to me! I may be reached at (phone number) during the months of January and February. After March 12th, at (phone number and address). Thank you for your participation!

Sincerely,

Karen Brown, PhC, RN, OCN
SUBJECT'S NAME: ___________________________________________ 
TITLE OF RESEARCH PROTOCOL: ________________________________
Nurse Empathy and Patient Satisfaction. 
PRINCIPAL INVESTIGATOR'S NAME: Karen Brown
RESEARCH PROTOCOL #: ________________________________

1. PURPOSE OF THE STUDY
The purpose of this study is to examine how nurse empathy may affect a patient's satisfaction with his or her nursing care.

2. PROCEDURE
The procedure for studying this relationship will consist of completing two brief surveys, one general information survey, and participating in a 1-hour tape-recorded interview 1 to 2 weeks after you have been discharged from the hospital.

3. RISKS AND DISCOMFORTS
Risks to you include the risk of embarrassment if your identity should become known through things and events you talk about during the interview. There will be no physical discomfort associated with this study, unless you have a physical disability that causes you pain when writing for short periods of time, or difficulty speaking.

4. BENEFITS
There is no direct benefits to you for participating in this study. However, it may benefit you to know that you have helped nurses and health care providers know what patients think is important in their nursing care, and to help future patients be more satisfied with their nursing care. This information learned in this study will be publicized to nurses and nursing schools and could change the way people are treated when in the hospital.

5. ALTERNATIVE PROCEDURES
You may choose not to participate in this study without any affect on your care or your relationship to XXXXXXXXX Hospital.

6. COST/PAYMENT
There is no cost to you for your participation, other than your time. You will not be paid for participating in this study.
7. **CONFIDENTIALITY**

Your identity will remain anonymous and your responses confidential. Your name will not appear anywhere in the report of the research. Your surveys, information sheet and interview notes will be coded so that your name will not appear on these records. The code key will be kept in a locked file drawer and destroyed when the research is completed. Any quotes from your interview will be presented with other quotes so that no one will be able to tell that you are being quoted. Any names mentioned during the interview will be changed.

I have fully explained to the Subject, ______________________, the nature and purpose of the procedures described above and such risks as are involved in its performance. I have asked the subject if any questions have arisen regarding the procedures and have answered these questions to the best of my ability.

_________________________  Investigator's Signature

I have been fully informed about the above procedure, with its possible benefits, risks, and consequences. I recognize that I am free to ask any questions. I understand that participation in this study is voluntary and I am free to withdraw from this study at any time without affecting my care or my relationship to XXXXXXXXX Hospital.

I will receive a copy of this consent form. XXXXXXXXX Hospital maintains and "Institutional Assurance of Compliance," a document that explains how the hospital provides for protection of human subjects, a copy of which is available upon request.

In the event physical injury occurs to me resulting from the research procedures, medical treatment will be available, if appropriate, at XXXXXXXXX Hospital. However, no special arrangements have been made for compensation or for payment for treatment solely because of my participation in this research study.

I hereby agree to become a subject in this investigation.

_________________________  Subject's Signature or Subject's Legal Representative when appropriate
I have witnessed the explanations made by the Investigator and heard the responses to questions. I have no conflicting interest in the activity proposed.

Date ___________________ Witness ________________________________

For any questions regarding the rights of a research subject, or information regarding treatment of research-related injuries, please contact: XXXXXXXXXXXXXXXXX, Director, Office of Research Administration and Policy, 735-4585. The University of Utah's IRB phone number is (801) 581-3655.
APPENDIX B

SEMISTRUCTURED INTERVIEW SCHEDULE
Primary Nurse

**Empathy**

What do you think/believe empathy is?

How does one convey empathy to another?

How would a nurse convey empathy to a patient?

What do you think you do to convey empathy? How do you know when you convey empathy?

What would you do to convey empathy toward your patient? How would you act to convey empathy toward your patient? What would you say to convey empathy toward your patient?

How does it feel when you are feeling empathic toward a patient?

Think of an ideal or role model nurse. Describe him or her. What does she/he say, do, think, how do they act?

Think of a poor or negative role model nurse. Describe him or her. What does she/he say, do, think, how do they act?

How are these nurses the same? How are they different?

How is empathy a part of nursing? What would you tell the negative role model nurse about what they could do to improve their nursing care?

**Patient Satisfaction**

Do you think it is possible for patients to be satisfied with their nursing care?

Why do you think it is important for patients to be satisfied with their nursing care?

What do you think patients think is important in influencing their satisfaction with nursing care? Why do you think these things are important? Would they be important to you if you were in the hospital?
If you were in the hospital, what sort of things would influence your satisfaction with your nursing care? What would satisfy you the most? What would satisfy you the least?

What do you do in your nursing care that you believe satisfies your patients the most? The least?

How do you know when your patients are satisfied with the nursing care you deliver?

Nurse Empathy and Patient Satisfaction

In your opinion, what effect does nurse empathy have on a patient's satisfaction with their nursing care?

How might it be possible that a patient might not be satisfied no matter how empathic the nursing care is? Has this happened to you? How did (or would) you feel when (if) this happened?

If you were given the chance to speak to a group of nursing students about what makes a good, caring, empathic nurse, what would you say to them?

Are there any other insights or things you would like to share with me and other nurses about nursing, empathy and/or patient satisfaction?
Patient

Empathy

What do you think/believe empathy is? (Definition: the capacity for participation in another's feelings or ideas.)

How does one convey empathy to another?

How would a nurse convey empathy to a patient?

What do you think the nurse would do to let you know she was feeling empathic toward you?
Is it important for a nurse to do this? Why?

How do you think the nurse would act if she was feeling empathic toward you?
Is it important for a nurse to do this? Why?

What do you think the nurse would say if she was feeling empathic toward you?
Is it important for a nurse to do this? Why?

What do you think the nurse would feel if she was feeling empathic toward you?
How would it feel to you if the nurse were feeling empathic?
Is it important for a nurse to do this? Why?

Think of a "perfect" nurse.
Describe him or her.
What does she/he say, do, think, how do they act?

Think of a poor nurse.
Describe him or her.
What does she/he say, do, think, how do they act?

How are these nurses the same? How are they different?

Patient Satisfaction

What do you think it would take for patient to be pleased with his/her nursing care?

Why is it important for patients to be pleased with their nursing care?

What do you think nurses think it is important to do or not do to make patients happy?
While you were in the hospital, what sort of things influenced your feelings about your nursing care? What did you like the most? What did you like the least?

Nurse Empathy and Patient Satisfaction

How do you think a nurse's ability to be empathic affects a patient's satisfaction with their nursing care?

Is it possible that a patient might not be satisfied with their nursing care no matter how empathic the nursing care is? When might this happen? Has it happened to you? How did (or would) you feel when (if) this happened?

Were you more satisfied with some nurses' care more than others? What made you more satisfied with some nurses? What made you less satisfied with other nurses?

If you were given the chance to tell nurses the things that were most important to you while you were a patient, what would they be? Why did you choose these examples/things?

If you had a niece or nephew who was interested in going into nursing and wanted to ask your opinion about what you thought was important for a nurse to know about being a good nurse to patients, what would you tell her or him?

Is there anything else about your nursing care and/or hospitalization that you would like to share with me and other nurses?
APPENDIX C

NURSE AND PATIENT DEMOGRAPHIC
QUESTIONNAIRES
Code______

Primary Nurse

Please complete the following demographic information. Fill in the blanks or circle the appropriate response. Your responses will remain confidential and be used for statistical purposes only. Thank you very much.

Age ___________  Sex:  F    M
Marital Status:  Single  Divorced  Married  Widowed
Number of children: _____  Ages of children: _____
Number of years you have worked as a nurse: ____________
Number of years you have worked at XXXXXXXXXX: _____
Number of years you have been a primary nurse: _______
Area of Nursing:  Med/Surg  OB/GYN  Oncology  Cardiology  Geriatrics  Other________________________

Basic nursing educational preparation:
  _Diploma
  _Associate Degree
  _Baccalaureate Degree

Highest nursing educational preparation:
  _Diploma
  _Associate Degree
  _Baccalaureate Degree
  _Master's Degree
  _Nursing
  _Nonnursing
  _Doctorate
  _Nursing
  _Nonnursing

Have you ever been a patient in any hospital?  Yes  No
If yes, how many times have you been hospitalized? ____

Has a loved one (spouse, parent, child, etc.) ever been hospitalized?

  Yes  No

THANK YOU FOR YOUR TIME AND ASSISTANCE.
Please take a moment to answer the questions below. Fill in the blanks or circle the appropriate answers. Your responses will remain confidential and will be used for statistical purposes only. Thank you very much.

Age:__________ Sex: F  M

Marital status: Single Married Divorced Widowed

Number of children: _____ Ages of children: _________

What is your highest level education? _______

Primary language (if not English): _______

Translator's relationship to patient: _______

Have you ever been a patient in the hospital before this most recent hospitalization? Yes  No

If Yes, how many time have you been hospitalized?
(circle one response)

1-10
11-20
21+

THANK YOU VERY MUCH FOR YOUR HELP!

If you would like a summary report of the findings from this research study, please complete the section below. I will mail you a brief summary when the research has been completed. Return this portion with your questionnaire.

Name_____________________________________________________

Address____________________________________________________

City/State/Zip_____________________________________________
APPENDIX D

NURSE EMPATHY DESCRIPTORS
Facilitators

accept  grounded
accurate  help
acknowledge  holistic
acting/action  honest
(not) advise  humor
advocate
astute
assess
assured
attend
attention
autonomous
balance
being there
"back and forth"
body language
bond

comfort  kind
comfortable  know
"click"
like
check in
check in
choice
open
"click"
listen/hear
"little things"

commit  mediate
communicate
pace
communication  prepare
confidence
control
conflict management
coordinate
compassionate
objective
organized

dignity

diversion  patience

disclosure
emotional connection
pattern recognition
experience  persistence
personal
personal experience  positive

facilitating  professional
familiarity  problem solve
feel with patient
flexibility

follow-up  professionalism
friendly

gentle  prompt

genuine
relating

rapport
re-direct
reliable
respect
responsible
safe/safety
self-knowledge
sensitive
sharing
silence
similar interests
sitting down
socialize
space
style
subtle/tact
support
talking
teaching
teamwork
thorough
time
touch - emotional
touch - physical
translate
trust
understand
validating
vivacious
warmth
Inhibitors

(not) accepting
acting before thinking
(not) advocating
angry
anxious
(not) astute

(not) being there

(not) calm
(not) caring
chose wrong profession
clumsy
cold
(not) communicating
(not) compassionate
(not) considerate
distance

emotions, intense

fake/not genuine
fear
(not) flexible
(not) focused
(no) follow-up

(not) hearing/listening

ignore
impersonal
inhuman
insecure
isolated

judging

(no) knowledge

lazy
(not) learning from
mistakes, experiences

mechanical/technical

out of tune
patronizing
(not) pacing
preoccupied

(no) presence
priorities (not patient's)

(not) qualified
(no) respect
robot-like
rude

(not) sitting down
(no) style

(no) talking
(no) time

unable to form relationships
uncomfortable

(not) understanding
unhappy
uninvolved

(not) validating
APPENDIX E

COMPLETE LIST OF CATEGORIES
Categories

Facilitating Attributes

The Nurse: The Person (See Appendix F)

Demographics
Sex
Age

Communication
Verbal
   communicates
   manages conflict
   acknowledges
   assesses
   informs
   reassures
   humorous
   mutual feedback
Nonverbal
   silence
   uses body language/eye contact
   touches (physical)
   listens

Comfort with others
   Understands
   Astute
   Open
   Spaces
   Accepts

Self-knowledge
   Present/"being there"
   Self-actualizes
   Intuits
   Balances
   Shares

Philosophy of life
   Values relationships
   Positive attitude
   Makes a difference

Hardiness
   Commits
   Challenged
Experience
Learns from experiences/people
Recognizes patterns
Holistic
Flexible
Persistent
Patient control
Plans
Redirects
Individualizes
Problem-solves

Qualities
Takes time/sits down
Friendly
Honest/genuine
Involved
Vivacious
Gentle
Imaginative
Cares
Diverts
Likes the patient
"Little things"
Checks in
The Professional

Demographics
- Nursing experience
  - less experienced nurses - more empathy
  - more experienced nurses - more empathy
  - no difference
- Nursing specialty
  - oncology

Communication
- Teaches
- Translates
- Subtle/tactful
- Communicates with team

Philosophy of nursing
- Loves nursing
- Gives good care
- Realistic
- Values relationships with patients
- Holistic
- Makes a difference

Experience
- Confident
- Knowledgeable
- Organized

Qualities
- Helps
- Calms
- Focuses
- Advocates
- Comforts
- Professional
- Consistent/reliable
- Respects
- Acts on information
- Prompt
- Safe
Inhibiting Attributes

The Nurse: The Person

Communication
not hearing/not listening
not talking
not astute/not understanding
no humor

Disengaged
distant/isolated/cold/impersonal/uninvolved
no time/not sitting down
insecure/fear

Enmeshed
enmeshed/no objectivity

Qualities
no focus/preoccupied/priorities different
inflexible/rigid/control/not pacing
patronizing/rough/rude
anxious/not calm
not caring/inconsiderate/not helping/not compassionate
fake/unhappy
angry
not learning from past experiences
lazy

The Nurse: The Professional

Communication
not teaching

Disengaged
distant/isolated
robot-like/mechanical
not being there

Enmeshed
interference

Qualities
ignore/not prompt
judging/not accepting
no follow-up/inconsistent/not advocating
intense emotion
The Patient: Positive Attributes
(See Appendix F)

Qualities
  positive attitude/"a fighter"
  positive experience
  appreciative

Philosophy of life
  loving/embracing life
  sense of spirituality
  acceptance of human condition

Experience
  knowledge/prior experience with health care system
  self-knowledge

The Patient: Negative Attributes

Qualities
  negative attitude
  complaining/unhappy
  suspicious
  angry/mean/rude
  passive/uninvolved in care
  depressed

Experience
  expecting nurses to be maids
  not knowing what nurses can do

Socioeconomic Status
  "VIP"
  wealth
Serendipitous Findings

Supporting Information
(See Appendix F)

Possibility of nurse empathy
not possible
is possible
conditional
facilitators
personal experience
common human experiences

Purpose of nurse empathy
comfort
care
help/make an impact
speed recovery

Nurse empathy/teachability
not teachable
cannot be developed even if person wants to
unempathic people don't see a need for it
is teachable
role model
precept
show
perceived need
can be developed if person sees a need
gift/inherent quality
"people person"
some have more of this quality than others

Nurse empathy/patient satisfaction correlation
very strong positive
mildly positive
didn't consider until interview

Role model
science/technical
art/psychosocial
combination
other
seeking person similar to self
Art/Science

Art of nursing
- empathy is art/one of arts of nursing
- human part/emotional bond/psychosocial
- how you do something
- individual for each person
- tricks learned with experience
  "street smarts"

Science of nursing
- technical/tasky
- physical care/physical demands
- thinking/intellectual
- physical demands override the art at times
  "book smarts"

Combining
- empathy -- art and knowledge combination
- balance between the two is important

Result of Relationship between Nurse and Patient

- Important to nurses and patients
- Relationship/rapport results in patient satisfaction
- Facilitates hearing and knowing

Possibility of Patient Satisfaction
- Is possible

Patient Evaluation of Their Care - Is It Possible
- Patients can and do evaluate their care
- Patients are the best judges of their care
- Don't need to be an expert to evaluate care
Relationship/Interaction  
(See Appendix F)  
(positive attributes)

Nurse Qualities

The person
  present/"being there"
  humor
  understands
  cares
  calms
  reassures
  patient/pace
  checks in
  shares
  friendly
  genuine
  open
  positive attitude
  likes the patient
  individualizes
  "little things"
  empathizes with patient
  accepts
  imaginative

The professional
  helps
  patient control
  flexible
  focuses
  astute
  respects
  knowledgeable
  organizes
  prompt
  safe
  teaches

Patient Qualities

involvement
  participate in plan and/or care
positive attitude
appreciative
consideration toward nurse
apologizing to nurse for behavior
not wanting to be a bother to nurse
Nurse-Patient Interaction

Nature of relationship
- personal
- bond/"click"
- involvement with each other
- like each other
- intangible to outsiders
- touch -- emotional/spiritual
- distance/space -- allowing for trusting
- holistic

Purpose of relationship
- advocate
- facilitates familiarity

Communication
- verbal and nonverbal
- respect
- rapport
- touch
- acknowledge
- mutual feedback
- listen
- intellectual understanding
- informing

Result of Relationship
- important to nurses and patients
- patient satisfaction
- nurse satisfaction
- facilitates familiarity

Environmental/Circumstantial
Time
Familiarity
Similar personalities
Similar interests/common ground
Consistency
Primary nursing
Less stress/fewer environmental demands
Nurse-Family Interaction

Nature of relationship
connecting/bonding

Purpose of relationship
work with family for patient benefit-
advocating/alliance around an issue
familiarity with patient through family

nurse actions
supports family
helps/facilitates family coping

family actions
supports nurse
apologizes for patient behavior
Relationship/Interaction
(negative attributes)

Nurse Qualities
(negative attributes)

The person

communication
not hearing/not listening
not talking
not astute/not understanding
disengaged
not sitting down/no time
distant/isolated/cold/impersonal/uninvolved

enmeshed
no closure - not knowing how or when to
come to closure with patient/family

attributes
no focus/preoccupied/priorities different
not caring/inconsiderate/not helping/not
compassionate
inflexible/rigid/no humor
fake/unhappy
anxious/not calm
angry
patronizing/rough/rude
not comfortable with others
not imagining
not learning from past experiences
lazy
not learning from past experiences
control/not adapting/not pacing

The Professional

communication
not teaching
disengaged
distant/isolated
robot-like/mechanical
not "being there"

professional qualities
judging/not accepting
not planning
intense emotion
not qualified/no knowledge
unorganized
ignore/not prompt
The Patient
(negative attributes)

Qualities
  negative attitude
  complaining/unhappy
  suspicious
  angry/mean/rude
  patronizing/disrespectful of others
  demanding/"deserving"
  selfish/spoiled
  strong personality/stubborn/close-minded
  intense/serious/no humor
  passive/uninvolved in care
  depressed
  emotionally regressed/immature/dysfunctional/
    manipulative

Coping patterns - ineffectual
  denial
  irrational/unrealistic
  uncooperative/resistant/ambivalent
  guilt/blaming - not taking responsibility
  control - trying to control things beyond control
  independence - trying to remain independent when
    this is not realistic/safe

Experience
  expecting too much
  not knowing what nurses can do

Physiologic factors
  dementia/ICU psychosis
Barriers to Nurse-Patient Interaction
(negative attributes)

Qualities of the participants (patient or nurse)
  passive
  negative/bitter
  strong personalities/stubborn/close-minded
  intense/serious/no humor
  suspicious
  adversarial/angry/violent/combative/mean
  intense emotions/upset/in crisis
  fear/trapped/helpless
  guilty/blaming
  anxious/stressed
  not open to relationships
  impersonal/cold/distant/"walls"/preoccupied
  history of rejection/abandonment (known)
  fear of getting close - fear of getting hurt

Quality of the interaction/relationship
  adversarial/angry/violent/combative/mean
  guilty/blaming
  manipulative

Nature of communication pattern
  not talking/not communicating
  mixed messages
  not listening
  not astute/not understanding

Nurse-Family Interaction (negative attributes)

Family attributes
  disengaged family
  not close
  not supportive
  enmeshed family
  protective
  possessive
  interfering

Environmental/Circumstantial
  No time
  Not familiar
  Team nursing -- little contact, nurses and patients
  Negative experiences with physicians
  Negative medical outcomes
  No follow-through (nurse to nurse)
Outcomes
(positive attributes)

Nurse Outcomes
(See Appendix F)

Nurse satisfaction facilitators
  appreciation - patient expression of
collegiality/peer recognition/appreciation
primary nursing
time - being able to spend time with patients
making a difference/having an impact
helping/giving service to others
nurse empathy
positive attitude

Nurse feelings
high - with positive patient experiences and/or
  outcomes
good - at being able to help others
love nursing/being in the right job

Nurse qualities
communication
  respect
  humor
  teaching/translate
  listen/hear
  share/self-disclosure
relationship skills
  involved
  bond/"click"
understand/know another
  like - the other
advice/forming an alliance around an
  issue
"little things" - liking to do
balancing skills
self-knowledge
  being there/presence
focused
  learn from experiences - personal
and professional
  positive attitude
distance/space
  closure - know when and how to
holism
organized
hardiness
  commitment
challenge
Patient Outcomes
(See Appendix F)

Patient satisfaction facilitators

physical improvement

the nurse - the person
astute
caring/compassionate
gentle
"being there"
comfortable
friendly
like
trust/believe
persistence/thorough
patient control/choice
flexibility
acceptance
checking in
informing
patient/pace
"little things"

qualities of the nurse - professional
help/support
calm
professional
focused
knowledge/smart
giving good care
organized
team communication
plan
prompt
safety
teaching

rapport with nurse
respect
communication/mutual feedback
listening
familiarity
understanding
touch

environmental factors
time to sit down
primary nursing
consistent nurses
cleaning personnel
expressions of satisfaction - reciprocity
thank you notes/letters
candy/edible gifts
gifts/flowers
recommend facility to friends

patient feelings - positive
pleased/impressed
Outcomes
(negative attributes)

Nurse Outcomes

nurse dissatisfaction - causes
stress
burnout
no balance
emmeshed
overinvolved/too close
no closure--not knowing when or how to
dependence--nurse, on patient relationships
disengaged
distant/cold/no relationships
not talking - holding it all in
how patient treated nurse
no respect
no trust/suspicious
adversarial relationship/angry/rude/mean
manipulative

nurse feelings - negative
angry/annoyed
hurt/upset
difficult/uncomfortable
frustrated
fearful/threatened
pessimistic/negative/unhappy
critical/judging

Patient Satisfaction Inhibitors

how nurse treated patient
angry/mean/rude
no time
didn't listen
didn't pace/pushed
cold/impersonal
robot
no communication
didn't understand
no trust
no help
no teaching
not astute
patient feelings - negative
angry/mad
anxious
frustrated
no trust/no confidence
APPENDIX F

CONCEPTUAL PERSPECTIVE OF THE NURSE, EMPATHY, AND PATIENT SATISFACTION
Figure 4. Personal and professional facilitating and inhibiting characteristics of the nurse and supporting information.
Figure 5. Patient outcome descriptors: Satisfaction or dissatisfaction.
Figure 6. The patient: Facilitating and inhibiting descriptors.
Figure 7. Nurse and patient relationship in hospital environment and circumstances.
Figure 8. Nurse outcome: Satisfaction facilitators and inhibitors.
Figure 9. Final conceptual perspective of nurse, empathy, patient satisfaction, and serendipitous findings.
APPENDIX G

COMMON DESCRIPTORS FOR NURSE EMPATHY AND PATIENT SATISFACTION
Facilitators

accepting
astute
believes
being there
calms
cares
checks in
communicates
focused
friendly
gentle
giving good care
helps
informs
knowledgeable
likes the patient
listens
"little things"
multiple feedback
organized
paces
patient control
persistence/thorough plans
professional
prompt
respects
safe
teaches
team communication
time to sit down
touches
understands

Inhibitors

angry
didn't believe
didn't listen
didn't pace
didn't understand
distant
no communication
not helping
not teaching
no time
not astute
robot
rude
APPENDIX H

NURSE EMPATHY, PATIENT SATISFACTION, AND RELATIONSHIP FACILITATORS
Figure 10. Similarities between nurse empathy, patient satisfaction, and relationship descriptors.
APPENDIX I

NURSE EMPATHY, PATIENT SATISFACTION, AND NURSE SATISFACTION DESCRIPTORS
Figure 11. Similarities between nurse empathy, patient satisfaction, and nurse satisfaction descriptors.
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