A Comparative Study of Nurses' Self-Report of Empathy with Patients' Perceptions of Nurse Empathy in Cardiac Outpatient Clinics in an Urban Hospital.

By

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfilment of the requirements of the degree of

MASTER OF NURSING

College of Nursing

University of Manitoba

Winnipeg, Manitoba

Abstract

Empathy must be at the heart of all nursing-patient encounters. This human connectedness is considered essential in the clinic setting and promotes the health and well-being of patients and their nurses. Guided by Hojat's (2009) and Davis' (1994) theoretical work, this comparative, descriptive study using a non-probability convenience sample, compared nurse empathy with 'real' patients' perception of nurse empathy in cardiac out-patient clinics of an urban hospital. A small qualitative component was also employed. This study did not find a correlation between nurse and patient perception of nurse empathy using the Survey of Nurse Perception of Own Empathy (SNPOE) and the Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE). Significant differences were found on scale items "what is happening in (the patients/my) life" and "was concerned about (me/the patient) and their family", patient age > 70 years of age, and advanced empathic training for nurses linked to nurse and patient perception of nurse empathy. Nurses identified four themes as barriers to the empathic process, *constrained time limits listening and engagement, challenging patient – nurse interactions impact empathy, a complex demanding care environment,* and *need for a leadership culture that supports empathy*. The nursing profession remains in need of an operational definition and a theoretical framework for empathy that incorporates both nurse and patient perspectives on nurse empathy. The inclusion of empathic care as a core competency for nurses in all position classifications and roles is needed. More research is needed for the promotion of advanced training in empathic care and in relation to nurse and 'real' patient perception of nurse empathy.

Acknowledgements

I am honored to acknowledge my thesis committee members, Dr. Michelle Lobchuk (thesis chair), Dr. Christina West (internal committee member), Dr. Deborah Gural and Dr. Mohammadreza Hojat (external committee members). Dr. Lobchuk expertise, wealth of knowledge and her gentle empathic approach, enabled me to successfully reach my goal as a graduate nurse. Dr. West and Dr. Gural gave me guidance and mentorship, commending me in times of success and knowledgeable advice in the more challenging times of my studies. Dr. M. Hojat kindly agreed to be an external advisor from afar. His expertise in the area of empathy in healthcare has helped me further develop my own views and understanding of this important concept.

I would like to thank the University of Manitoba, Faculty of Nursing, and Graduate Studies for providing me with a challenging, educational opportunity to grow as a nurse leader. I also wish to acknowledge Red River College Nursing Faculty for their continued support. I sincerely appreciate being part of such a supportive environment.

A special thank you to the nurses, patients, hospital management and staff, who graciously gave their time and support to make this study possible.

With all my love, I thank my husband, Rob, and my family, for encouraging me to reach for the stars. You gave of yourselves in so many ways so I could would be successful.

Dedication

I would like to dedicate this research to two very special women in my life.

My mother – Irene Wilson

My mother-in law – Audrey Moran

Your individual journeys through health care in your final years of life enlightened me to the importance of empathic care of patients and their families.

To you both, I will forever love and miss you.

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Chapter One – Introduction

Statement of the Problem

When there is an encounter with someone in need, the likely response is to feel empathy. This empathic response then elicits a helping behaviour (Batson, 1997; Davis, 1994). In the 1800's, Florence Nightingale insisted that nurses place "oneself imaginatively and sensitively in the world of the other" (Norman, 1996 p. 313). Today, empathy is considered a core element of patient/or/client-centered communication in a clinical setting (Carper, 1978; Parkin, de Looy, Farrand, 2014). Positive health outcomes of individuals living with illness have been correlated with heightened awareness and implementation of empathy by their health care providers [HCP's] (Freedberg, 2007, Remeson & Lieberman, 2012).

There is growing evidence that the active, deliberate, and learned cognitive process involving communication, language skills and perspective taking can be influenced to bolster a greater understanding of a health care situation, and promote helping behaviour by the HCP toward the patient (Davis, 1994). The responsiveness of the health care provider who understands the patient's point of view can positively affect the nurse-patient relationship and choices made by the patient and his or her family within the context of health care decision-making.

Nursing is considered both a science and an art. Empathy must be at the heart of all nursing-patient encounters (Ward, Cody, Schaal, & Hojat, 2012). The ability to be empathic is a desirable characteristic in a nurse (Penprase, Oakley, Ternes & Driscoll, 2013). Peplau's (1997) Theory of Interpersonal Relations underscores the importance of the nurse-patient therapeutic relationship in connecting with the patient, as well as communicating knowledge and understanding. This human connectedness is considered essential in the clinical setting and

promotes the health and well-being of patients and their care providers (Ward et al., 2012). However, it can be difficult to develop this connectedness given the significant influence of the biomedical model on nursing practice. This biomedical framework has become far more complex and often encourages “curing over care, efficiency over excellence and technical prowess over personal technique” (Ward et al., 2012, p. 35). Studies have also indicated that lack of time, lack of support from colleagues, individual personality characteristics and anxiety in the clinical setting can negatively affect empathic communication (Ward et al., 2012). Interestingly, nursing students are reported to have a decline in empathy as they accumulate experience in their clinical settings (Ward et al., 2012). Ward et al. (2012) also commented on the decline or under-development of empathy of nursing students as they experience a lack of support, difficult patient assignments, limited time to complete tasks, and fear of making mistakes. Taken together, these findings suggest that the decline of empathy in nursing students may have a sustaining impact on empathy-related behaviours by post-graduate nurses in clinical practice where barriers have been well documented as described above.

From the patient’s perspective Reynolds and Scott (2000) found that patients do not experience empathy in the nurse-patient relationship. Furthermore, it is suggested that self-reports of empathic communication reported by health care professionals (HCP’s) may be a result of how the provider would like to communicate empathy with patients rather than how they are actually communicating empathy (Ward, 2012). A review of the literature reveals that, few studies (Reynolds & Scott, 2000) have examined the relationship between the self-reported empathy of nurses to the perception of empathy a patient feels they received from their nurse in clinical encounters.

Purpose of the Study

The purpose of the study is to describe how patients and nurses in ambulatory cardiac care out-patient clinics compare in their perceptions of empathy during clinical out-patient encounters.

Theoretical Perspective

Davis's Organizational Model of Empathy [OME] (1994) will serve as a conceptual framework that guides this researcher's study of the empathic communication and consultation process, and nurse characteristics that influence this process as perceived by nurses and patients in the context of ambulatory care. The OME presents a linear empathic process that leads to empathy-related helping behavior. The purpose of the OME is to serve as a tool to help researchers identify and clarify interrelationships between constructs and sub-constructs of the empathic process. Davis (1994) differentiated between antecedents of the empathic process, and empathy-related outcomes within a situation that made it possible for him to identify gaps in empathy research (Appendix A). This researcher adapted Davis's (1994) model to depict the variables and relationship of interest to the current study (Appendix B).

Antecedents of empathy. Davis (1994) defined antecedents as characteristics of the observer that influence the likelihood that he or she will engage in an empathy-related process or experience an empathy-related outcome. Antecedent variables can include tendencies to engage in an empathic process, based on experiences of the observer and the level of distress associated with being a witness to another person's suffering or distress (Davis, 1994). The observer's past experiences and the intensity or duration of the distressing or negative situation being witnessed, can also influence the unique response of the observer. In health care, Hojat (2007) argued that the ability of the HCP to have an empathic response toward a patient is also determined by his or

her past experience and relationships, present situation, preconceived ideas, barriers, or awareness of one's self and the ability to effectively communicate feelings, and imaginatively step inside a patient's world. The environment, genetic predisposition, compassion and sensitivity toward others, emotional responses toward others, and the levels of subjectivity in evaluating others' experience can also contribute toward the degree of empathy experienced by an individual (Freedberg, 2007). Conscious desire and active listening are also important antecedents of an empathic response (Campbell-Yeo, Latimer, & Johnson, 2008). Definitions and attributes of empathy in HCP's consistently illustrate the need to have good skills at communicating, perceiving, and experiencing while remaining objective (Hojat et al., 2011; Posick et al., 2014). Other attributes have been examined that provide some insight into the influential impact of the empathic process. Empathy can occur in varying degrees and can be demonstrated (or not) depending on the individual's characteristics (Freedberg, 2007; Posick et al., 2014). The antecedents related to communication, perception, conscious desire, active listening, experience, present situation, preconceived ideas, barriers, and awareness of one's self, ability to step inside a patient's world, emotional responses and level of subjectivity in evaluating others will be examined in the current study.

Empathic process. Davis (1994) proposed that the emotional and cognitive dimensions of empathy emerge over several stages in a relationship. The emotional dimension of empathy is triggered in the first stage of engagement when the observer vicariously feels the same emotion as the other person who is in some distress or in a difficult situation. In the second stage, the observer may then be motivated to engage in the cognitive dimension of perspective-taking to aid him or her in garnering sensitive insights into the other person's perspective of the distressing or difficult situation (Batson, Early & Salvarani, 1997; Davis, 1994). The intrapersonal

perspective-taking process involves the observer's cognitive attempt "to understand another by imagining the other's perspective" (Davis, 1994, p. 17) and is generally attributed to the interpersonal outcome of helping behaviours by the observer. Perspective-taking is a mentally effortful activity that involves self-awareness and emotional regulation (Lobchuk, McClement, Daeninck, & Elands, 2007; Gerdes, Lietz & Segal, 2011) that can otherwise 'colour' how one understands the other person's viewpoint of the situation, if not controlled by the observer.

Overall, the empathic process occurs when the observer's affective and cognitive responses evoke a conscious decision in the observer to engage in 'other-oriented' empathic behaviours such as helping the other individual in a way that is sensitive to that person's viewpoint or response to the situation (Davis, 1994; Hojat, 2007: Hojat et al., 2011). Put more simply, to be empathic means having been emotionally evoked to engage in a cognitive process that leads to "other-oriented" helping behavior.

Empathic outcomes. According to Davis's (1994) model, the third stage involves intrapersonal and/or interpersonal outcomes. As a result of having engaged in the cognitive process of perspective-taking. Davis (1994) identified the intrapersonal outcome of accurate understanding of another person. In other words, as the result of having 'imagined' the other person's perspective on the situation, the observer attains a more accurate, 'other-oriented' understanding of the other person's thoughts, feelings, and perspective of the situation. Interpersonal outcomes can involve the observer's engagement in sensitive, 'other-oriented' helping behaviours (Davis, 1994; Gerdes et al., 2011). As a result of having engaged in the cognitive process of perspective-taking, interpersonal outcomes like helping responses by the observer toward the individual may occur (Davis, 1994). Empathy-related helping by the observer can include explicit responses such as communicating sensitively with the individual,

making attempts to validate one's inferences about the feelings, thoughts and experiences of the individual, and offering 'other-oriented' social support or assistance to the individual in the distressing or difficult situation. After the communication of empathy has been demonstrated the person receiving empathy feels understood and cared for, while the one who demonstrates empathy feels an altruistic satisfaction having assisted another which fulfills a need to be useful to others (Davis, 1994). This researcher is interested in examining the nurses empathic encounter with patients (via self-report and patient's perceptions) in the current study.

Controversies around empathy. Of note, individuals will not experience all three stages of empathy to the same degree. It is dependent on the individual's level of ability, skill, motivation and, experiences that has an impact on the degree of empathy in a given situation (Davis, 1994; Gerdes et al., 2011; Posick et al., 2014). Empathy is considered to be an inherited trait that is further developed as individual's age and are influenced by their environments (Davis, 1994; Posick et al, 2014; Schweler, Costa, Antoniao, Amaral, & Carvalho-Filho, 2014). Sociological and biological factors have an impact on an individual's level of empathy and capacity to actively demonstrate empathic behaviour (Davis, 1994; Posick et al., 2014). Zahn-Waxler, Robinson, and Emde (1992) studied the cognitive and affective components of empathy and found that empathy influences the behaviour of individuals, but empathy is not always an automatic response. This line of thought suggests that empathy is a cognitive process that can be controlled by the individual.

On the other hand, Campbell-Yeo et al. (2008) stated that empathy consists of both autonomic and neurological responses that may not be fully controllable by the conscious intent that creates the vulnerability to act (or not), before the consequences of the action have been deliberated. Still other authors have described that the ability to understand someone includes a

biased response from personal experiences and an internal reference of self-awareness (Mearns & Thorne, 2007; Williams & Stickley, 2010).

Definition of Research Variables and Other Terms

Empathic Process: A cognitive and behavioral effort by the nurse who embraces a 'patient-oriented' viewpoint to comprehend and support the patient who is making decisions that may or may not be in concordance with medical recommendations for optimal treatment of an illness (adapted from Davis, 1994).

Empathy: "A predominantly *cognitive* (rather than emotional) attribute that involves an *understanding* of (rather than feeling) experiences, concerns and perspectives of the patient, combined with a capacity to *communicate* this understanding and an intention to help" (Hojat, 2016, p. 80).

Patient-centered care: "Providing care that is respectful of and responsive to individual patient preferences, and needs, and values, and ensuring that patient values guide all clinical decisions" (Institute on Medicine, 2001, p. 3).

Research Questions

The following questions will be addressed in this descriptive comparative study:

<u>Quantitative Component</u>

1. What are ambulatory patients' perceptions of the empathic approach of nurses in the outpatient cardiac clinic? (descriptive question)
2. What are nurses' perceptions of their empathic approach in the outpatient cardiac clinic? (descriptive question)
3. How do the patients' and nurses' perceptions of the empathic approach of nurses compare in the outpatient cardiac clinic? (comparative question)

4. What nurse characteristics are linked to their empathic approach taken in the out-patient cardiac clinic?
5. What patient characteristics are linked to their empathic approach taken in the out-patient cardiac clinic?

Qualitative Component (Nurse only)

6. What circumstances make it easier for you [registered nurse] to engage in empathic care with patients in the outpatient cardiac clinic? (Qualitative – Nurse)
7. What circumstances make it harder for you [registered nurse] to engage in empathic care with patients in the outpatient cardiac clinic? (Qualitative-Nurse)

Significance of the Study

Based on a review of the literature on empathy in clinical practice, this researcher identified a gap in empirical work. There are few studies that examined how nurses and patients compare in their perceptions of nurse empathy in clinical practice. Moreover, this researcher identified only a few studies on nurse empathy from a Canadian perspective (e.g., Bourgault et al., 2015). Factors that facilitate or negatively influence the empathic approach embraced by nurses also need to be identified for future discussion related to a change in practice. As guided by Davis's (1994) OME model, this research aims to describe patient and nurse perspectives of nurse empathy, and capture influential nurse and patient characteristics as well as workplace barriers and facilitators that impact nurse empathy. These study findings will make a significant contribution to knowledge on nurse empathy and provide evidence-informed recommendations on how to enhance and support nurses as they practice empathy, particularly in ambulatory care settings that is currently not well identified in the literature. Accordingly, this study's findings

have potential to influence practice policies and evidence-informed guidelines on empathy-driven patient-centered care in the ambulatory care settings.

Chapter Two – Review of the Literature

The purpose of this researcher's review of the literature is to identify extant empirical works and summarize the current state of knowledge regarding empathic relationships between the nurse and patients in clinical practice. Based on this review of the literature, the researcher was able to comprehend the perceptions of the nurse and the patient regarding the empathic approach taken by the nurse in the therapeutic relationship. To facilitate the review of the literature, the researcher performed an extensive review of classical and contemporary literature (1900's to 2016) related to empathy using English-language dictionaries, relevant websites and academic databases including the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane, PsychINFO, and PubMed. Peer reviewed and empirical literature was reviewed. The main search terms included empathy, patient-/client-/family-centered care, health care, well-being, patient outcomes, communication, nurse, and health care professional (HCP).

Empathy in Health Care

Empathy is a key aspect of care that recognizes the affective and cognitive component of nurses' perceptual understanding of patients' thoughts and feelings about their situation (Carper, 1978). The concept of empathy is critical in developing a helping relationship where the patient feels understood. Empathy has been found to correlate with effective, positive outcomes in those who are cared for (Freedberg, 2007; Pehrson et al., 2016). The capacity to communicate and understand the unique meanings of the patient's feelings and thoughts through sensitive awareness and affirmation of the patient's experience has been attributed to empathic behaviour (Mearns & Thorne, 2007; Pehrson et al., 2016; Williams & Stickley, 2010). The benefits of empathic communication in health care are significant as described below.

In healthcare literature, it is well documented that empathy is central in the development of a therapeutic relationship. Empathy positively effects patient outcomes by promoting enhanced patient management of disease, lowering health care costs, lowering the rate of medical errors, and increasing client satisfaction with the HCP (Bayne, Neukrug, Hayes, & Britton, 2013; Brown, & Busell, 2011; Hojat, 2007, Pehrson et al., 2016; Rolfe, Cash-Gibson, Car, Sheikh, & McKinstry, 2014; Strandberg, Eklund, & Manthorpe, 2012; Williams & Stickley, 2010; Williams et al., 2014; Yu, & Kirk, 2008). Patients who perceive that they have an empathic relationship with their health care team are more likely to adhere to treatment regimes, recall and understand medical information, have increased coping mechanisms in managing health concerns, and have an improved quality of life (Hojat, 2007; Hojat, 2016; Bayne et al., 2013).

Empathic HCPs experience increased personal well-being (Bourgault et al., 2015; Hojat, 2009; Hojat, 2016). Empathy has a positive effect on the consolation process related to clarifying patient concerns, beliefs and treatment options, patient-HCP communication and patient perceptions of the HCP's attention to their concerns. Enhancement of the empathic experience provides a deeper patient-orientated understanding by the HCPs of the patient's situation by the HCP, leading to a higher quality of care (Carper, 1978; Davis, 1994; Kelley, Lepo, & Frinzi, 2011; Parkin de Looy, & Farrand, 2014; Pehrson et al., 2016). Canadian researchers studied the relationship between empathy and well-being among emergency nurses. They found that nurses who had higher empathic characteristics scored higher in their personal wellbeing (Bourgault et al., 2015). Their findings are consistent with other findings where medical residents with higher empathic scores reported higher levels of well-being and spent more time attending to their patient's experience (Shanafelt, West, & Zhao, 2005). Conversely, a breakdown in the empathic

process, as impacted by feelings of anger and resentment in professional or family caregivers has the potential to negatively affect HCPs and family caregivers' helping responses and patient satisfaction, adherence, and outcomes (Davis, 1994; Doyle, Hungerford, Cruickshank, 2014; Lobchuk, McClement, McPherson, & Cheang, 2008; 2012).

Professional empathy in health care is differentiated from general empathy due to its high demand in the health care environment and the need for health care professionals to regulate their emotional resources, and appropriate empathic responses on a daily basis (Ekman, & Halpern, 2015). Professional burnout has been associated with diminished empathy in HCPs who allow their negative attitudes and judgment of patients' self-care management and risk taking behaviours to guide their practice and engagement with patients (Ekman, & Halpern, 2015; Halpern, 2003; Linden & Redpath, 2011). HCPs often impose professional and emotional boundaries between themselves and patients and their families in order to shield themselves from emotional pain (Bayne et al, 2013; Burks & Kobus, 2012; Halpern, 2003). The ability to recognize and share another's emotional state is a complex inner experience that requires self-awareness. Self-awareness helps the HCP to establish appropriate boundaries between the patient's experience and the experience of the HCP. This process of developing self-awareness enables the HCP to listen and learn more about a client's situation (Eisenberg, 2000; Halpern, 2003). HCPs who demonstrate higher empathy and well-being scores tend to be: compassionate, motivated to connect with clients, competent in their field of practice, and flexible with assessment and treatment plans (Bayne et al., 2013; Bourgault et al., 2015; Duarte, Pinto-Gouveia, & Cruz, 2016).

Mindfulness skills are also important to empathy (Beckman et al., 2012; Duarte et al., 2016). Mindfulness in nursing is defined as "a transformative process, where one develops an

increasing ability to experience being present with awareness, acceptance, and attention" (White, 2014. p. 283). A nurse who is adept at applying mindfulness skills in practice is better able to enhance a sense of meaning and satisfaction in the ever-changing health care environment. Improving one's mindfulness skills such as taking time for personal growth and reducing one's psychological distress and burnout are warranted otherwise the ability to be empathic may be impeded (Beckman et al., 2012; Duarte et al., 2016; Fahlberg & Roush, 2016). Development of mindfulness strategies that encourage reflection and awareness of thoughts gives the HCP the opportunity to respond to a situation rather than suppress it or get caught in the emotional experience of the client (Ekman, & Halpern, 2015; Duarte et al., 2016; Stern & Divecha, 2015; Winning & Boag, 2015).

The HCP's ability to cognitively understand a patient's perspective, and communicate their understanding of the patient's viewpoint in combination with an intention to help is fundamental to the concept of empathy in patient-centered care (Epstein & Street, 2011; Hojat, 2007; Kelly, Lepo, & Frinzi, 2011; Stern & Divecha, 2015). The focus on empathy within the scholarly literature has increased over the past decade. This provides significant support for empathy as a key component for the enhancement of the HCP-patient relationship in client-centered care (Dinkins, 2011; Hojat, Axelrod, Sprandorfer, & Mangione, 2013; Ozcan, Olfax, & Bakir, 2012; Santo, Pohl, Saiani, & Battistelli, 2014). There is also increasing evidence that regional health care authorities, such as the Winnipeg Regional Health Association (WRHA), are encouraging empathy in HCPs and in the clinical health care setting. The WRHA stated in the Family Medicine-Primary Care Operational Guidelines that "the therapeutic relationship between the primary care provider/team and patient is viewed by both parties as a long-term relationship built on empathy, equity, and respect" (WRHA, 2014, p. 1).

In summary, the role of empathy in the health care system is well documented in the literature. Ekman and Halpern (2015) stated that empathy is "a critical, although not thoroughly understood aspect of patient care and an important ingredient for feeling work satisfaction and meaning" for HCPs (p. 633). The professional definitions and attributes of empathy consistently describe the need for HCPs to have patient-centered skills in communicating, perceiving, and experiencing while remaining objective (Hojat et al., 2011; Posick et al., 2014). Despite growing evidence to support empathy in patient centered care, patients continue to perceive a lack of empathy in the health care system (Bayne et al., 2013; Williams, & Stickley, 2010). The support in both education and the workplace that is needed to aid in enhancing the empathic process that underlies good communications skills has not been well studied (Lobchuk et al., 2007).

Empathy and Patient Adherence in Health Care

Illnesses that are treated with pharmacological therapies can be very effective in combating disease. However, 50% of patients who would benefit from the medication regimes do not take their prescribed medication, 60-80% of medical information received by patients is not retained, and 34-50% of patients do not understand their treatment plan (Bodenheimer, 2008; Brown & Bussell, 2011; Sabate, 2003). Non-adherence to treatment is of great concern to all stakeholders in the health care profession, including physicians, nurses, health educators, policy makers, and government agencies (Sabate, 2003). Difficulty adhering to treatment of a chronic condition limits the potential of the patient to effectively self-manage their care to improve their health and quality of life (Brown, & Bussell, 2011; Sabate, 2003). The inability to adhere to medication regimes is frustrating not only to the patient but also their HCP.

The World Health Organization (WHO) stated that a change in health care practice can make a bigger difference in clinical outcomes then a change in treatment regimens (Sabate,

2003). Research has demonstrated that HCPs assume that patients should be motivated by their illness to follow treatments outlined with standard protocols and discussed with their HCPs, yet this assumption is erroneous (Sabate, 2003). Patients will adhere to treatment only if they are in agreement with the health care plan and they are able to implement the plan. Interventions that are adherence-promoting are not consistently implemented in practice by HCPs (Sabate, 2003). Therefore it could be said that non-adherence is a concern not only to patients but also the health care system and HCP's. Could empathy be 'that' health care practice in patient centered care that is foundational to an effective and efficient health care system?

To summarize, motivation to adhere to medical treatments involves more than following recommended treatment plans. Understanding what motivates an individual patient, how illness and treatment affects their families and their lives from the patient's perspective is a crucial component in the adherence to a medical regimen. If a patient is not adhering to a prescribed treatment, it behooves the HCP to comprehend the thoughts and feelings of the patient so as to approach the situation sensitively from a patient-centered stance.

Empathy and Patient-Centred Care

Communication problems between the HCPs and their patients often results when the HCP focuses solely on the disease, and its management, rather than on the patient (e.g., the unique life of the patient, the patient's family, and the patient's understanding of the health problem (Dwamena et al., 2013). Over the past two decades, health care advocates have attempted to shift the focus of health care away from the biomedical model that focuses on disease to patient/client/family-centred with a focus on knowing the whole person (Bayne et al., 2013; Hojat, 2007). For the purpose of this discussion, the term *patient-centred care* will include the term client-centred care.

Patient-centred care was introduced in the Institute of Medicine's (IOM) quality chasm report as a key element in providing high quality health care (Epstein & Street, 2011). Patient-centred care is defined as "providing care that is respectful of and responsive to individual patient preferences, and needs, and values, and ensuring that patient values guide all clinical decisions" (Institute on Medicine, 2001, p. 3). Patient-centred care involves four common elements: being attentive to the patient's physical and psychosocial needs, allowing for the discovery of the patient's concerns, promoting partnership in the relationship between the patient and the HCP, and facilitating decision making through patient involvement (Lee & Lin, 2010). Patient-centred care encourages empathic communication to engage the patient in a two-way sharing of information that facilitates the discovery of the true nature of a patient's situation leading toward HCP helping behaviour (Bayne et al., 2013; Hojat, 2007; Windover et al., 2014). If the patient does not feel listened to, the patient can become disengaged in the clinical encounter and not share vital information as part of a shared decision-making process where the patient's viewpoint plays an influential role in care. It is imperative that during the clinical encounter that the patient's perspective is acknowledged and supported and that the patient does not feel controlled (Lee & Lin, 2010). While HCPs may engage in offering options to care, often the approach taken is paternalistic and medically-driven: for example, when patients are asked, "Do you want this drug or this drug", clinicians are not practicing true patient-centred care (Hojat, 2007; Government of Manitoba, 2015).

HCPs need to recognize when an empathic opportunity arises in the HCP-patient relationship. This is an essential component that drives patient-centered care. However, HCPs often miss or terminate an opportunity to continue the conversation that could improve the client's situation (Hojat, 2009; Pehrson et al., 2016). Often in clinical encounters, HCPs do not

validate or acknowledge the stressors a client is trying to express (Brown, & Bussell, 2011; Mayberry & Osborn, 2014; Osborn, & Egede, 2012; Pehrson et al., 2016; Yu & Kirk, 2008). These stressors can seriously detract from realizing the goals of patient-centred care. In conjunction with recognizing an empathic opportunity, empathic curiosity is vital to stimulating meaningful communication and engagement with others (Halpern, 2003; McEvoy & Plant, 2014). Empathic curiosity encourages the nurse to actively listen, ask questions, detect emotional cues, and explore what the patient is expressing in the present moment (McEvoy & Plant, 2014; Pehrson et al., 2016).

Another characteristic that is vitally important in patient-centred care is emotional intelligence [EI] (Akerjordet & Severinssoon, 2010; Carragher & Gormeley, 2016). Emotional intelligence is described as "a multi-factorial array of emotional and social competencies that determine how effectively we relate with ourselves and others and cope with daily demands and pressures" (Carragher & Gormley, 2016, p. 86). The ability to distinguish between emotion and reason aids in understanding the empathic approach from both the cognitive and emotional perspective, and facilitates thinking and the managing of emotions in both the nurse and the patient. EI is a valuable characteristic in nursing leadership that can aid in fostering empathy for those around them in health care settings (Akerjordet & Severinssoon, 2010; Carragher & Cormeley, 2016).

The Registered Nurses' Association of Ontario [RNAO] (2008) clinical best practice guidelines for Person-and-Family Centered Care have stipulated that an effective behaviour by nurses to improve care is "eliciting and responding to emotion with the use of empathy, understanding, and, caring" (p. 37). Establishing an empathic relationship between the HCP and the patient including the patient's family has been positively correlated to the patient's ability to

engage in conversations regarding treatment options, the medical process, and willingness to provide information and seek clarification. An empathic relationship also encourages the patient to take an interest in collaborating with the HCP to create a treatment plan that is unique to the patient and his or hers perceived needs (Bayne et al, 2013).

Research has demonstrated that an empathic HCP is a key factor in promoting partnership in the treatment process between the HCP and the patient. Patients who felt that they were actively engaged in the care process demonstrated increased adherence behaviour and positive health outcomes (Sabate, 2003). HCPs who provided emotional support, shared information and promoted the building of partnerships have better patient outcomes than those who do not (Sabate, 2003).

In their systematic review, Dwamena et al. (2012) studied the impact of interventions on clinical outcomes, patient satisfaction, healthcare behaviour and health status in clinical consultations. The investigators concluded that training physicians and nurses to improve their skills in sharing control of decision-making with their patients during consultation has been connected with successful outcomes for the patient. The inclusion of educational materials, communication skills training, and teaching sessions for HCPs added to patient satisfaction and improved health outcomes Dwamena et al., 2012; Pehrson et al., 2016). More research is needed to determine the effect of these interventions in aiding patients to improve their health care behaviours (Dwamena et al., 2012).

In summary, this review of the literature demonstrated that empathy is considered a fundamental concept in patient-centred care. Support, role modeling by leaders, educational opportunities and interventions are needed to encourage HCPs to engage in the four elements of patient-centered care that include: being attentive of the patient’s physical and psychosocial

needs, allowing for the discovery of the patient's concerns, promoting partnership in the relationship between the patient, and the HCP, and facilitating decision making through patient involvement.

Empathy and Strengths-based Nursing Care

Strengths-based care (SBC) considers "the whole person, focuses on what is working and functioning well, what the person does best, and what resources people have available to help them deal more effectively with their life, health, and health care challenges" (Gottlieb, 2013, p. 1). SBC encourages caring for patients by focusing on an individual's "personhood and humanity" (Gottlieb, 2013, p. 1). HCPs, including nurses, care for patients and, families by identifying their strengths in order to aid in healthcare decision-making. Identifying strengths rather than weaknesses refocuses attention to what is working rather than on what needs fixing. Looking for strengths provides an opportunity to identify possibilities for improving quality of life. Essential qualities required for SBC include mindfulness, humility, open-mindedness, non-judgmental attitudes, curiosity, self-reflection, respect and trust, compassion and kindness, courage and self-efficacy and most importantly, empathy (Gottlieb, 2013).

In summary, empathy is recognized as the most important component in providing SBC care to a person. Empathy is relational and can help a nurse to gain insight into a person's strengths and challenges. In determining the patient's strengths and challenges, a nurse is better able to develop treatment plans that are individualized to that patient. The patient who feels that their HCP demonstrated an empathic approach to care, were less likely to be distressed and more satisfied with the care they have received (Pehrson et al., 2016; Yu & Kirk, 2008).

Empathy in Nursing Practice

Empathic communication is considered to be at the heart of the nurse-patient relationship (Carper, 1978; Ward et al., 2012). Patients and their families value nurses who are caring, compassionate, communicative and, nurturing. Empathy is considered foundational to each of these values (Palos, 2014; Ward et al, 2012; Ward, 2016). Each of these qualities is essential in providing patient-and-family centred care that is strength based (Palos, 2014).

Empathy is not a new concept in nursing. Florence Nightingale, modeled and encouraged empathic relationships between patients and nurses' in the mid 1800's, before the term empathy was formally introduced in the English language (Clements & Averill, 2006; Ward et al., 2012). Ida Orlando, nursing leader and founder of 'The Dynamic Nurse Patient Relationship' (Orlando, 1961) postulated that there is a reciprocal relationship formed between the patient and the nurse, which encourages the nurse to identify the patient's needs and to find solutions to meet these needs. Barbara Carper (1978) is another nursing leader who borrowed the concept of empathy from psychologist Carl Roger's (1958). She formalized the importance of empathy in nursing when she introduced a conceptual framework that included the Four Fundamental Patterns of Knowing that included: (a) *empirics*, is described as empirical, generalizable, factual and, objective of knowing; (b) *esthetics* takes into consideration conditions, situations and, experiences; (c) *personal knowledge* takes into account knowing oneself, and, (d) *ethics* as the moral component in nursing. Carper (1978) described empirics as the science of nursing and esthetics, personal knowledge and ethics as representing the art of nursing. She also suggested that empathy is a key component of esthetics through effective and necessary communication strategies for patient centred care. Jean Watson (1979), founder of Theory of Human Caring

believed that nurses promote and develop a helping trusting, authentic, and caring relationship by employing direct and respectful communication that draws on the foundation of empathy.

These former conceptualizations of empathy in the clinical setting were contradicted by Morse, Bottorff, Anderson, O'Brien, and Solberg (1992). These authors argued that empathy is "uncritically adopted from psychology" and a "poor fit for the clinical reality of nursing practice" which influenced a shift away from empathic communication in nursing practice (p. 277). Morse et al. (1992) contended that nurses' ought to focus on pity, sympathy, compassion, consolation and commiseration, rather than on empathy. Morse et al. (1992) stipulated emotional empathy as the nurse being able to feel for the patient and that therapeutic empathy is not attainable due to barriers that included: (a) the transient nature of the clinical setting; (b) the stage of coping with reality that the patient is in; (c) a lack of time spent with patients; (d) the lack of privacy to establish rapport; and (e) the possibility of being interrupted by another patient. Morse et al. (1992) also rationalized that nursing assignments change regularly and hospital stays are often less than ten days which contributes to the inability to have a therapeutic empathic nurse-patient relationship. Morse et al. (1992) wrote: "It is incredible that this obvious fact has remained unnoticed in nursing" (p. 277).

Reynolds and Scott (2000) questioned whether nursing and other health care professionals display empathy in their practice. Their findings suggested that empathy among nurses is not demonstrated at the level necessary to understand the concerns and values of their patients, which is consistent with findings from earlier studies. Reynolds and Scott (2000) discussed the possibility that empathy in the healthcare system is stymied by limited consensus on how empathy is defined, the devaluing of empathy in healthcare, and doubts about whether

the benefits of therapeutic relationships can be achieved during limited patient-HCP encounters which was similarly addressed by Morse et al. (1992).

Authors such as Morse et al. (1992), Carper (1978) and Reynolds and Scott (2000) agreed that nursing is a unique profession that requires knowledge which is not "borrowed" and without adaptation from another profession. For instance, the development of empathy theory for nursing practice and nursing knowledge is needed to bridge the gap from nursing education to nursing practice. Empathy theory for nursing practice should include consensus of a nursing practice- based conceptual definition of empathy, theoretical postulations on the relationship between empathy and nurse-patient therapeutic communication and, positive empathy-related outcomes from the patient and family, the HCP and the health care system. Morse et al. (1992) contended there is a need to have consensus on the definition of empathy as it relates to nursing which includes a conceptual framework and an understanding of the importance of empathy in therapeutic communication. With the recent insurgence of empathy as a key to patient-centred care, Dinkins (2011) postulated that empathy underlies the art of nursing and conceptualized empathy to be not only a "feeling or an instinct but as a practice" (p. 1).

Recently, the College of Registered Nurses in Manitoba [CRNM] (2012) mandated that entry-level nurses require empathy as a skill for 'relational practice' and empathy is a key characteristic for professional nurse practice. Of note, while core competences for nurses in advanced practice (i.e., nurse practitioners and clinical nurse specialists) describe that patient-centred care is valued in nursing, this researcher identified that core competencies do not explicitly identify empathy as a key driver of this type of care (Canadian Nurses Association [CNA], 2008/2010/2014; CRNM, 2011). As well, this researcher identified that empathy is not explicitly addressed in the Canadian Code of Ethics (2008), although it has been cited as one of

the main building blocks in nursing that supports ethics and ethical conduct in treating others with care and kindness (Dinkins, 2011; Vanlare, Coucke, & Gastmans, 2012, Ward et al., 2012).

Nurses are expected to be experts in scientific knowledge and technical expertise therefore making it necessary to have a broad range of academic and clinical experiences to be competent in their role (Palos, 2014). Continuing to provide evidence-informed practice that is research and theory based and integrated with clinical expertise, are qualities expected in the science of nursing (Palos, 2014). However, the delivery of evidence-informed practice involves the third component known as patient preferences and values. It is not prudent to implement practice without knowing the patient's and family's preferences and values (Melnyk & Fineout-Overholt, 2011). The ability to competently synthesize the art and science of nursing to meet the complex needs of the patient and family can be perplexing and overwhelming for even the most experienced nurse. As nursing roles continue to expand, the required ability to competently synthesize scientific knowledge and complex technical skills with the art of nursing through interpersonal relationships that are characterized by empathic communication can be overwhelming for practicing nurses (Palos, 2014).

To summarize, nurse leaders and researchers have offered evidence and argumentation in support of the need for nursing theory on empathy as an integral and positive component in the art of nursing and the nurse-client relationship. However, this researcher identified a concern for the expanding role of the nurse where ethics and core competencies set by the CNA and CRNM require further attention with regard to empathy in nursing practice. Integrating empathy in the clinical setting would be enhanced by the development of conceptual clarity, an operational definition and a conceptual framework model that guides the practical application of empathy in evidence-informed practice.

Empathy Decline in Practice

Undergraduate nursing students, both male and female, have significantly high mean scores of empathy in comparison to students in other undergraduate programs such as dentistry, and occupational therapy (Penprase et al., 2013; Petrucci, La Cerra, Aloisio, Montanari, and Lancia (2016). However, several teams of researchers described that there is a significant decline in empathy scores of nursing students in their final year of study from when they entered into their respective programs of study (Schweller et al., 2014; Ward et al, 2012). An empirical study of nursing students who had more clinical exposure and patient experience, including increased technical skill and prior work experience, had a statistically significant decline in their mean empathic scores in comparison to students who had less clinical and patient experience (Schweller et al, 2014; Ward et al, 2012; Ward, 2016). Factors cited by Ward et al. (2012) that impeded empathic behavior's in nursing students included a lack of time, lack of support from unsympathetic colleagues, personality traits, and anxiety in situations with patients. Similar factors were reported by Reynolds and Scott (2000) where student nurses with lower empathic scores stated they felt vulnerable in crisis situations that were new to them. They stated they needed more empathic support from colleagues in order to feel they could openly discuss their fears, concerns and worries.

Facco, Cirio, Galante, and Dimonte (2014) described similar results with post-graduate nurses who reported a decline in empathy scores that were in direct correlation with increased exposure to clinical practice (e.g.. increased length of time in one clinical setting). These findings on nurse empathy corroborate other study findings that focused on medical students and practicing physicians (Grossman et al., 2014; Hojat, 2009; Ward et al., 2012; Ward, 2016).

In summary, both nursing students and post graduate nurses can experience a decline in empathic skills with increased educational and clinical experience. As the role of the nurse becomes more complex and scientifically oriented, nurses are challenged to provide empathic care in the medically modeled health care system.

Nurse Characteristics Linked to Empathy

Davis (1994) reported that the unique characteristics of an individual influence the likelihood of the person either engaging in an empathy-related process or experiencing an empathy-related outcome. Certain characteristics are brought to any given situation that will potentially influence the process and outcome of the encounter (Davis, 1994). The intellectual capacity to engage in empathy related processes and outcomes includes biological capacities, previous learned history and individual differences, the level of intensity or duration of the situation, and similarities between people experiencing the encounter (Davis, 1994). On the other hand, there is an expectation that empathy is inherent within individuals who have the capacity to supportively communicate and understand the unique meanings of feelings through sensitive awareness and affirmation of another person's feelings (Mearns & Thorne, 2007; Williams & Stickley, 2010). It is assumed that empathy occurs in varying degrees in a given situation, and can be demonstrated or not depending on the individual and the circumstances (Davis, 1994; Freedberg, 2007, Posick, et al., 2014). Throughout this discussion, it has been emphasized that being empathic with others is a desirable characteristic of the nurse in providing care to the patient (Penprase et al., 2013).

A number of researchers have also examined the linkage of nurse characteristics with empathic behaviours in basic training and in clinical practice. Demographic characteristics of nurses have been linked to their empathic approach taken with patients that include: age, gender,

number of years of nursing experience in a specialized area, and the overall nursing experience (Vioulac, Aubree, Massy, & Untas, 2016). Although it is agreed that genetic predisposition influences the empathic process, the environment, personal experience, types of relationships, emotions and feelings of subjectivity that occur over a lifetime also have a direct impact on a person's empathic helping response to a given situation (Freedberg, 2007; Posick, et al., 2014). For the purpose of this study, the researcher is interested in basic demographic and experiential characteristics of the nurse participant that include; gender, age, amount of experience in the specialized field, overall nursing experience, and the nurse's current designation (i.e.: nurse - RN, nurse III – clinical /resource nurse specialist, nurse IV – nurse educator, nurse V – Nurse Practitioner [NP], and the nurse's educational designation.

The gender and age of the HCP has been examined as factors that can impact the clinician's empathetic approach. In basic training, studies result by Penprase et al. (2013) and Petrucci et al. (2016) showed that both male and female students in baccalaureate nursing programs had significantly higher levels of empathy then those enrolled in other university health care programs such as occupational therapy, dentistry, physiotherapy, and human nutrition. However, male nursing students reported lower empathic scores then their female counterparts (Penprase et al., 2013). Gosselin, Bourgault, and Lavoie (2015) found that the age of a nurse in critical care areas can negatively influence their psychological wellbeing and reduce empathy, especially in younger nurses.

The amount of experience in their specialized field and amount of overall nursing experience is also a factor that can influence an empathic attitude (Bourgault et al., 2015). As stated earlier, empathic scores were found to decline in direct correlation with increased exposure to clinical practice (Facco et al., 2014) which included nurses working in specialized

areas (Vioulac et al., 2015). The nurse's role is also a characteristic that can influence empathy in the work environment. Nurse leaders, including managers, who are empathic are better able to role model empathy for other nurses (Mortier, Vlerick, & Clays, 2015).

Overall, literature on nursing practice consistently describes empathy as the foundation that promotes a therapeutic relationship between nurses, patients and their families. Nurse characteristics found to be associated with empathy include: age, gender, years of experience in a specialized field, years of experience as a nurse, and level of education.

Patient Characteristics Linked to Perceptions of Nurse Empathy

This researcher did not locate any empirical studies that reported on patient characteristics that are associated with their perceptions of nurse empathy. However, Rahmqvist and Bara (2010) studied characteristics of patients from the patient satisfaction perspective. Their study identified several common patient characteristics and quality dimensions that related to overall patient satisfaction rates in out-patient hospital care. The results indicated that poorer health status, younger patients, and an increase in reception wait times correlated negatively to overall patient satisfaction. Older patients, patients who experienced good health status and felt that they had received expected medical help, and patients who reported that they were treated well by the HCP correlated positively to patient satisfaction (Rahmqvist & Bara, 2010). Overall for the purpose of this study, the patient's age, gender, health status, time spent in the reception area, and their perception of receiving the treatment they expected will be targeted in the researcher's systematic examination of the association between patient demographic characteristics and their perceptions of nurse empathy.

Perceived Barriers to Empathic Clinical Practice

This next section describes the researcher's review of literature on perceived barriers from the patient's and nurse's viewpoints on empathic approaches enacted in clinical encounters. From the client's perspective, the following studies identified a lack of empathy and paternalistic attitudes in nurses. Larsson, Sahlsten, Segesten, and Plos (2011) highlighted barriers that were perceived by patients which affected their participation in patient care. Key qualitative themes of "Meeting a lack of empathy", being "Met without interest" and being "Met without a sensitive ear" (Larsson et al. 2011, p.577) were emphasized when patients felt that they were unable to make an emotional connection with their nurse or that the nurse was unwilling to determine what had value and meaning to the patient. These authors also described that when patients met with paternalistic attitudes and a lack of empathy by nurses, they felt vulnerable and tended to take a passive role in their health care. This researcher has noted that there is limited research from the nurse's and patient's perspectives regarding perceived barriers to empathic care in clinical encounters.

Well known authors such as Halpern (2003) have observed and speculated on perceived barriers to the empathic approach in the clinical setting. The anxiety of a HCP about the delivery of care will impede the ability of the HCP to be empathic toward patients (Halpern, 2003). Health care providers may lack the knowledge to understand that patients have emotional needs that can impede core aspects of illness and care. None-the-less, many HCPs believe that they do practice patient-centered care and empathy with their patients despite evidence of divergent perceptions by patients in health care settings (Dwamena et al., 2013; Halpern, 2003). Often HCPs believe that being empathic will lead to professional burnout (Ekman & Halpern, 2015; Halpern, 2003; Linden & Redpath, 2011). HCPs often impose professional and emotional

boundaries with their clients and their families in order to shield themselves from emotional pain. Being empathic is seen as a vulnerable, negative or a weak position to be in (Bayne et al, 2013; Burks & Kobus, 2012; Halpern, 2003). On the other hand, Brown (2012) stated that having the courage to allow vulnerability to enter the patient-HCP relationship humanizes the HCP and provides an opportunity to experience the patient's situation. Contributing to perceived barriers is the perception that benefits of empathic communication in health care are not significant (Hojat, 2007; Hojat, 2016; Bayne et al., 2013). There are many individuals in health care who believe that empathy cannot be taught (Hojat, 2007) or that there is not enough time to be empathic (Dyche & Epstein, 2011). Organizational attitudes often contribute to the devaluation of empathy in healthcare (Cosgrove, 2014).

Although HCPs may receive training in empathic communication, a number of work-related barriers can arise as a deterrent for them to engage in an empathic stance. Morse et al. (1992) stated that there is not enough time to be empathic in a clinical setting. On the other hand, recent studies have indicated it can take less than 90 seconds for a patient and a HCP to come to a shared understanding of what is important to the patient (Halpern, 2003). Often HCPs who lack awareness of the importance of empathic communication confuse haste with efficiency (Dyche, & Epstein, 2011; Halpern, 2003). Researchers have concluded that the use of empathic communication can decrease the overall amount of time spent in consultation as patient outcomes are directly addressed and their satisfaction increases with the clinical encounter (Bayne et al., 2013; Hojat, 2009).

Not all patients are receptive to the HCP's attempts to be empathic and these patients' attitudes can impede the empathic approach. For instance, patients who are angry during the clinical experience or patients who are motivated by the need to obtain medication to feed their

substance abuse addiction will likely not allow for a empathic connection to be formed (Bayne et al., 2013). Patients who prefer to have their HCPs “tell” them what to do rather than take an active interest in their care will not encourage empathic communication or may not be willing to share their experience. Some patients are easier to connect with than others because they are more verbally or non-verbally expressive in their communication with HCPs. Bayne et al. (2013) suggested that patients who experience language barriers, a lack of interest in communicating, have intellectual difficulties or are unable to understand or comprehend situations due to cognitive challenges potentially impede the therapeutic relationship (Bayne et al, 2013).

In summary, this researcher found limited empirical evidence on nurses’ and patients’ perceived barriers toward empathy in clinical encounters outside of those reported by Morse et al. (1992). Instead, this researcher reported on authors’ speculations on barriers in the clinical setting from the HCP’s perspective such as lack of time, fear of professional burnout, and misconceptions related to the concept of empathy and its relationship to patient-centred care. Intuitively, each of these speculated barriers have the ability to negatively influence the nurse’s empathic approach taken with their patients. Patient anger, frustration with unmet goals in clinical encounters, passive attitudes, and personality types, lack of confidence or motivation to communicate one’s needs, challenges with language, cognitive difficulties, and misunderstanding health-related information are plausible contributing factors that can have an impact on whether the occurrence of empathic exchange occurs in clinic encounters with HCPs, including nurses. Drawing on Davis’s (1994) OME model, researchers need to further examine linkages between hindering and facilitating factors that influence nurse empathy in clinical encounters. Such information is vital to developing and testing interventions designed to boost the empathic process in the workplace and in the clinical encounter.

Empathy Training Interventions and Models

In recent years, there has been a growing body of empirical work by researchers in psycho-neurology that provides suggestive evidence that empathy is a 'trainable' physiologic reaction to another's emotional experiences. For instance, Kelly et al. (2011) reviewed the neurological basis for humans to understand and conceptualize empathy. Human brains have the ability to mirror the emotions that are observed in others. Complex neural systems within the human brain replicate a "similar pattern of neural activity that is occurring in another person's brain" (Kelly et al., 2011, p. 22) allowing for the ability to form connections to another person and their subjective experience (Kelly et al., 2011). Based on their evidence that empathy is an objective neurological response, Kelly et al. (2011) suggested that empathy-enhancing strategies can provide nurses with opportunities to improve their empathy as a physiologic reaction (i.e., learning how to mirror the emotions of patients in healthcare encounters). Mirroring the emotions of others warrants ongoing investigation on benefits to the patient and to the nurse.

HCPs who have been trained in the empathic approach, defined empathy as a form of detached cognition that suggests the need for HCPs to remain objective when communicating empathically with patients (Hojat et al., 2011; Hojat, Michalec, Veloski, & Tykocinski., 2015). On the other hand, Halpern (2003) argued that HCPs who are empathetic remain emotionally attuned to their patients, which can help HCPs to determine what has personal meaning for the patient, be attentive to what is significant, and be more trustworthy to patients who in turn disclose important information that can help improve their outcomes. The HCP who is empathic towards their patients reports greater satisfaction and meaning in their work life (Halpern, 2003). Health care providers who are taught to maintain a natural curiosity about their patients experiences will likely refrain from making hasty judgments, benefit from listening to patients

and can aid in making appropriate diagnosis and treatment plans that include the patient's values and beliefs (Halpern, 2003; Hojat, 2007).

Empathy is amenable to positive change and can be taught (Davis, 1994; Hojat, 2009). Davis's (1994) Organizational Model of Empathy (OME) addresses how the empathic process can lead to helping behaviour and provides the theoretical foundation for teaching the empathic process to clinicians. Perspective-taking is the underlying cognitive process of empathy that can be taught to nursing students, and post-graduate nurses where they are instructed on how to imaginatively "step inside another person's shoes" to garner a better understanding of the client's situation from the client's perspective (Urbanik, & Lobchuk, 2009). Davis's (1994) OME model was developed based on pooled evidence that the active, deliberate and learned cognitive process of empathy (I.e. perspective taking) can be influenced to encourage a greater understanding of another person's difficult or distressing situation. For instance, as a result of having engaged in the cognitive activity of perspective-taking, the nurse is more likely to be motivated to engage in sensitive, patient-oriented helping behaviour (Batson, Early, & Salvarani, 1997; Davis, 1994; Lobchuk, McClement, Daeninck, Shay, & Elands, 2007).

Basic education. In basic education, students are often taught to practice an empathic approach with their patients with simple techniques such as sitting at the patient's level, limiting patient wait times, and ensuring that the patient and their family are comfortable. Empathic communication skills taught to students include: active listening, using open ended questions, paying attention to verbal and non-verbal cues of patients and themselves, and focusing on the client (Cunico, Sartori, Marognollie, & Meneghini, 2012; Hojat, 2009; Ward et al., 2014). A review of the literature found that nursing and medical students reported improved empathy scores and an increased ability to develop therapeutic relationships with their patients after

undergoing empathic communication training (e.g., Dwamena et al., 2013; Hojat et al., 2013; Moore, Mercado, Artigues, & Lawrie, 2013; Ozcan et al., 2012; Schweller et al., 2014). More specific, strategies have been studied for use with students and include: training in interpersonal communication and language skills; engaging in audio-or video-taped feedback of encounters with clients and the HCP; exposing oneself to role models; engaging in role playing; consulting with client navigators; participating in simulated hospitalization experiences; studying literature and the arts; improving one's narrative skills; and, engaging in theatrical performances and literature (Cunico et al., 2012; Hojat, 2009; Ward et al., 2014). Cunico et al. (2012) conducted a longitudinal study where they found enhanced instructional training courses for student nurses significantly improved their empathic skills over their three year nursing program. With growing evidence on the effectiveness of instructional training courses on empathy with students, Williams and Stickley (2010) argued that it is the responsibility of nurse educators to ensure that nursing students are provided with an education that promotes empathy in their practice. However, Dean and Williams (2017) stated that the ability to provide empathy training in nursing education is increasingly being taught through the use of patient simulators, high fidelity mannequins. These researchers suggest the use of patient mannequins as a style of learning does not provide the students with realistic communication skills and possible runs the risk to favour technical, data driven leaning in place of the more holistic patient centered approach.

This researcher's thesis supervisor (Lobchuk) is currently leading the development and testing of a novel theory-based (as guided by Davis's [1994] theory) perspective-taking video-feedback intervention that is designed to 'boost' undergraduate nursing students' engagement in a 'caregiver-oriented' stance to better comprehend caregivers' motives for engagement in health risk behaviour. This intervention is based on empirical recommendations for key ingredients of

effective empathy training that include: didactic training on empathy principles, video-taped dialogue, and feedback on performance. Lobchuk intervention is comprised of three phases where the nursing student: (1) is taught and practices an ‘imagine-other’ perspective-taking stance in comprehending another person’s health risk behaviour (e.g., smoking, poor diet, or lack of exercise); (2) engages in a 10-minute video-recorded dialogue with a ‘real’ or ‘actor’ family caregiver; and (3) participates in a video-feedback and video-training exercise to determine his or her accuracy in comprehending the caregivers’ thoughts or feelings in the video-recorded dialogue on the health risk behaviour (Lobchuk, Hala, West, harder, Tursunova, & Ramraj, 2016). The hypothesis is that students who engage in the empathy-based video-feedback intervention will attain enhanced empathic consultation scores, and higher perceptual congruency with caregivers on the caregiver’s thoughts and feelings experienced about the health risk behaviour and caregiving situation. Dr. Lobchuk’s aim is to develop a sound, acceptable, and economical intervention for uptake in basic and continuing education for nursing students and post-graduate nurses, as well as other health care professionals in promoting their empathic attitudes towards individuals in their care (Lobchuk et al., 2016).

Continuing education. The recent focus to enhance empathic communication in basic training curricula for medical and nursing students is also being addressed in continuing education to meet the communication needs of post-graduate clinicians. Efforts to improve empathic communication skills have had good results. Ancel (2006) reported a significant increase in empathy pretest and posttest scores from 155.6 to 180.5 units for 236 nurses who took part in five sessions of an in-service communication training program. Bonvicini et al. (2009) examined an educational intervention using audiotaped interaction with physicians. The study reported significantly improved empathic expressions during patient interactions. The

study did not focus on physicians' self-reports of empathy but on physician's audiotaped interactions using a third-party coding system and real-life physician-patient encounters. A systematic review undertaken by Kelm, Womer, Walter, and Feudtner (2014) reported that in highly rigorous study designs interventions to cultivate empathy in medical students, fellows, residents and physicians increased empathy scores. Of note, few of the studies included in this review examined empathy from the patient's perspective.

A growing number of programs are being offered in the United States and Canada that teach clinicians about compassion- and empathy-based therapeutic relationships and the application of related behaviour in clinical practice. For example, The Centre for Compassion and Altruism Research and Education (CCARE) at Stanford University offers research and education modules on compassion (i.e., a broad concept that is related to empathy). In Manitoba, the Catholic Health Corporation of Manitoba [CHCM] has established the Compassion Program in partnership with CCARE to provide educational opportunities to develop skills that enhance compassion, empathy, and kindness through educational initiatives and incentives. Their motto includes 'Being-Caring-Doing' (CHCM/CCARE, 2016; http://www.chcm-ccsm.ca/compassion-project).

Another model that this researcher was introduced to at the Patient Experience: Empathy and Innovation Summit (2015) in Cleveland, Ohio was the REDE Model for clinical practice. According to this model, there are four empirically validated phases in the clinical empathic process with patients and their families include: Relationship, Establishment, Development and Engagement (REDE) by HCP's. The model is currently being offered in continuing education in the United States in collaboration with the model's developers from the Cleveland Clinic Academy (CCA) (Windover et al., 2014). The REDE model was developed as a practical

learning tool to meet learning objectives of HCPs in communication training (Windover et al., 2014). Through reflection and refinement, the model maximizes previously learned communication skills that enhance empathy (Windover et al., 2014). The Model also employs the mnemonic SAVE to cue the HCP during consultation to practice empathy by reminding oneself about: S or support “Let’s work together”; A or Acknowledge “This has been hard on you”; V or validate “Most people would feel the way you do”; and E or emotion naming “You seem sad”. It is not expected that different types of empathic statements are necessary for each encounter nor are these statements meant to replace the HCP’s natural and authentic response to provide empathic care (Windover et al., 2014).

Bayne et al. (2013) developed a comprehensive model for optimizing empathy in patient-centered care. Through a qualitative study that involved both physicians and patients, Bayne et al.’s (2013) model was centred on the HCP role in facilitating empathic care. The model is depicted by a number of sequential ‘physician process’ that include: Physician Qualities, Internal Barriers, External Barriers, Initial Empathy, and Genuine Empathy. Bayne et al., (2013) reported on the association linking ‘Patient Role in Physician Empathy’ with ‘Results of Empathy’. This model was structured to establish physician qualities that may facilitate or promote empathy, identify barriers that may limit the empathic process, and measure the impact of physician empathy on patient outcomes.

In summary, empirical evidence indicates that empathy can be taught. Published studies have validated the positive effects of interventions that enhance HCP’s empathy across health care disciplines. Empirical evidence continues to grow that is helping to identify essential elements of effective strategies to train students and clinicians in compassionate, empathy-based relationships with individuals (and their families) in their care. Each model represents concepts

that are potentially useful in education and provides new directions for empathy research and ongoing evidence-based development of empathy training strategies for uptake in basic and continuing education. For instance, more studies are required to systematically examine the long-term or sustained impact of empirically-based strategies on patient (e.g. satisfaction, and adherence to recommended therapies) and health care professional (satisfaction, perceptual understanding, and decreased burnout) outcomes.

Transformative Change towards Empathy in Health Care Settings and Organizations

As more students and clinicians are being trained to embrace the empathic, patient-centered approach, health care organizations and stakeholders need to support empathy in health care. Health care in Canada has entered into a period of transformative change (Hutchison, Levesque, Strumpf, & Coyle, 2011). This transformative change involves setting goals and objectives for health care that include a greater emphasis on HCPs to encourage patient engagement and self-management of health through patient-centred care. Canadian health care organizations are being encouraged by the Canadian government to redesign practice to focus on effectiveness and efficiency of care that is evidence-informed and where patient engagement is harnessed as an effective factor in care efficiency (Hutchison et al., 2012).

Cultural change within an organization is often difficult and requires modeling by its leaders. Leaders within an organization who embrace change and take ownership of their actions and powerful positions to improve their establishments are essential in promoting engagement by clinicians in empathic provider-patient relationships (Cosgrove, 2014). Emergent evidence by Hojat, Bianco, Mann, Massello, and Calabrese (2015) demonstrated significant linkages between empathy, teamwork, and integrative patient-centered care that can be helpful for transformative change led by organizational leaders. These authors provided evidence on how crucial

interpersonal communication skills are in understanding the experiences of patients (e.g. pain, suffering, and unique concerns) by collaborative, inter-professional teams. Therefore, implementing improvements in empathic communication and teamwork approaches, and developing an increase in HCP awareness of an integrative approach to patient-centred care could potentially improve patient outcomes (Hojat et al., 2015).

To summarize, empathy is considered a positive attribute in relationship-building that can lead to effective leadership within an organization (Hojat et al., 2015). Investment in education and training to promote empathy in practice can result in reduced expenditures and unwarranted use of resources over time (Ekman, & Halpern, 2015). Effective empathic communication also has a positive influence on overall health care spending, and in helping clinicians to make more accurate diagnosis without unnecessary tests (Bayne et al, 2013; Hojat, 2007; Strandberg et al., 2012; Williams, & Stickley, 2010). Health care leaders need to be familiar with empirical findings that demonstrated that a lack of empathy has negative consequences on client care, job satisfaction and the effectiveness of the overall health care system (Doyle, et al., 2014; Hojat, 2007).

Conceptualization of Empathy and Related Concepts

Despite growing evidence for the importance of empathy in the provision of sensitive patient-centered care by nurses and other HCPs, there remains a lack of consensus about how to define empathy in health care literature (Hojat, et al., 2011). A number of concepts exist that are often confused with empathy, which will be discussed below.

Synonyms for empathy include sympathy, compassion, pity, responsiveness, identification, and ‘fellow feeling’ with the antonym for empathy being indifference (Empathy, 1986). However, words with similar meanings lose the quality of the word (Davis, 1994; Hojat,

2007). For example, sympathy and empathy are both important components of interpersonal relationships and are often used interchangeably. However, having sympathy for someone is to feel 'for' them but to have empathy is feeling 'with' them (Davis, 1994; Hojat, 2007). While the sympathetic response "I am sorry" may be an attempt to demonstrate 'feeling' concern for the patient, it can discourage the HCP from acting on empathic curiosity to cognitively appraise the situation and communicate a helping behaviour that is driven by the patient's needs (Dyche, & Epstein, 2011; McEvoy & Plant, 2014; Hojat, 2009; Santo et al., 2014). Similar to empathy, compassion involves the ability to objectively and affectively understand. However, compassion does not involve the need to provide helping behaviour which is found in empathy (Sinclair et al., 2016). Compassion involves emotions and actions based on love, vulnerability, and reciprocity (Sinclair et al., 2016).

Empathy is an abstract psychological construct that is not clearly observable (Davis, 1994; Hojat, 2007). Developmental and social psychology researchers differentiate the concept of empathy as an experience that contains affective and cognitive decision-making elements (Gerdes et al., 2011; Posick et al., 2014). One's ability or motivation to engage in empathy can change over time in response to cultural, societal, and contextual changes while also being modifiable through communication, language skills and perspective-taking (Hojat, 2007).

The term empathy originated from the German word Einfuhlung (from ein 'in' + fuhlung 'feeling'). Empathy was first used in 1858 by the German philosopher Rudolf Lotze as a translation of the Greek word, empatheia which means 'passion, state of emotion' from the assimilated form of en 'in" + pathos "feeling'" (Empathy, 1986 p.742). Originally, the term empathy was translated into German to describe the theory of art appreciation and its dependence on the viewer's ability to "project his personality into the viewed object" (Empathy, 2014). The

word empathy was introduced in the English language in 1903 to capture imagining, and feelings of the mind with the ability to feel into the works of art and nature (Lanzoni, 2012).

The term empathy was adopted by noted psychoanalysts, including Titchener, Visher, Lipps, and Paget (Lanzoni, 2012; Norman, 1996). Psychotherapist Carl Rogers popularized the term empathy in 1958 and defined empathy as "the ability to perceive the clients private world as if it were your own, without ever losing the as if quality" (cited in Norman, 1996, p.315). Interestingly, the general use of the word empathy was modest in the English language until the 1950's when Roger's deemed empathy had a major role to play in therapeutic communications with a patient (Halpern, 2003; Hojat, 2007). Nursing theorist Barbara Carper (1978) described empathy as the "capacity for participating in or vicariously experiencing another's feelings" (p. 27) and the more skilled the nurse becomes in empathizing with patients the more likely the nurse is able to design effective nursing care. Webster's Third New International dictionary (1986) definition of the word empathy demonstrates the history of art appreciation:

> "1. The imaginative projection of a subject's state whether affective, or cognitive into an object so that the object appears to be infused with it: the reading of one's own state of mind or conation into an object (as an artistic object)
>
> 2. The capacity for participating in or a vicarious experiencing of another's feeling, volitions, or ideas and sometimes another's movements to the point of executing bodily movements" (p. 742).

For the current study, this researcher will adopt the following definition of empathy in the context of the nurse-patient therapeutic relationship: Empathy is a "predominantly *cognitive* (rather than an emotional) attribute that involves the ability to *understand* (rather than feel) experiences, concerns and perspectives of the patient combined with a capacity to *communicate*

this understanding and an intention to help (Hojat, 2016, p. 80). Hojat (2016) and colleagues created this definition in response to the need to have a medical definition for the term empathy. Ward et al. (2012) use this definition to highlight the "significance of the construct of empathy in the context of the nurse-patient relationship" (p. 34).

Other attributes that provide some insight into the influential elements of the empathic process include: having the ability to see situations as others see them, being non-judgmental, and understanding another's feelings, and communicating one's understanding through a behaviour or action and self-awareness (Davis, 1994). Similarly, Hojat (2007) identified the following characteristics that typify the empathic process: being self-aware and nonjudgmental, exercising one's imaginative ability to see the situation as 'the other' sees the situation, understanding what the other person feels, and communicating one's understanding through a behaviour or action.

To summarize, empathy continues to be an abstract concept with numerous definitions and dimensions. Empathy has been described as a cognitive attribute, an emotional state of mind, behaviour, or a combination of all three. Fundamental differences that exist between cognition, emotion, and behaviour, including the difference between empathy and sympathy, obstructs the ability to study and measure empathy. The definition for empathy proposed by Dr. Hojat and his colleagues (2007) combines the ability to cognitively understand the experience, concerns and perspectives of the patient, and communicate this understanding with the overall goal of enacting a helping behaviour by the HCP is the definition that will be applied in the current study.

Empathy Tools

In the context of this study of the nurse-patient relationship, empathy is defined as a "predominantly *cognitive* (rather than an emotional) attribute that involves the ability to

understand (rather than feel) experiences, concerns and perspectives of the patient combined with a capacity to *communicate* this understanding and an intention to help (Hojat, 2016, p. 80). This definition was developed by Dr. M. Hojat and his colleagues at the Center for Research in Medical Education and Health Care, Jefferson Medical College in the United States. Hojat (2007; Hojat, 2016) views empathy as emerging from cognitive mental processing that includes the individual's reasoning and appraisal of a situation, as well as the ability to overcome overwhelming emotion (i.e., described earlier as a key feature of sympathy). Davis's (1994) OME also described the cognitive dimension of empathy, otherwise known as perspective-taking, that is amenable to change and can lead to enhanced understanding and 'other-oriented' helping behaviour. In the HCP-patient relationship, the ability to understand the patient through cognitive appraisal must be accompanied by the ability to communicate this understanding (Hojat, 2007).

A definition or conceptualization of empathy for nursing practice needs to reflect expectations of the nurse to promote a therapeutic relationship with a patient through optimal communication and patient-oriented understanding (Ward, 2016). There have been many tools developed to measure empathy. However, there are inconsistencies between the tools based on the ambiguous definitions leading to the complexity of measuring empathy (Hojat, 2007; Yu, & Kirk, 2009).

This researcher conducted a critique of available empathy tools that aided in the selection of an appropriate tool for use with nurses and patients in a busy ambulatory cardiac care clinic setting in this study. Measurements that are commonly used to assess nurse empathy in health care were considered. This researcher was guided by recommendations arising from a systematic review conducted by Yu and Kirk (2008/2009) on the following empathy tools: Barrett-Lennard

Relationship, Carkhuff Indices of Discrimination & Communication, Emotional Empathy Tendency Scale, Empathy Construct Rating Scale, Hogan Empathy Scale, Interpersonal Reactivity Index, Jefferson Scale of Physician Empathy, Layton Empathy Test, Perception of Empathy Inventory, Reynolds Empathy scale, and the Visual Analogue Scale. For the purpose of this research, tools that have been suggested by Yu and Kirk (2009) to be administered in health care and/or nursing settings will be appraised for their reliability and validity potential to measure nurse empathy as experienced by nurses and patients in clinical encounters. One tool, not critiqued by Yu and Kirk (2009) will also be included.

Carkhuff Indices of Discrimination & Communication [CIDC]. This instrument was originally developed by Carkhuff (1960) to appraise cognitive and behavioral dimensions of effective communication and discrimination indices including empathy. The CIDC did not specifically measure empathy. The CIDC has been used with counselors in psychology and to evaluate the effectiveness of training programs. This researcher was unable to identify evidence that reported on the validity of the tool. Reliability for test-re-test is 0.95 and inter-rater reliability is 0.89 (Yu & Kirk, 2009). This researcher could not find an operational definition or theoretical basis that guided the development of the CIDC. The CIDC was not considered appropriate for this study because it did not directly measure cognitive and behavioral dimensions of empathy within the clinical context of the nurse and client engagement.

Empathy Construct Rating Scale [ECRS]. This instrument was originally developed by female graduate students in psychology and nursing. LaMonica (1981) continued to develop the ECRS for use with nurses and patients in hospital settings. The ECRS was developed to capture the cognitive and behavioral domains of empathy (Yu, & Kirk, 2009). Face and content validity were judged by a panel of three judges and nurse experts. Internal consistency, split-half

reliability and test-re-test scores were conducted and the Cronbach's alpha reliability estimates ranged from 0.89 to 0.98. This researcher found the tool to be lengthy (i. e., an 84-item scale), and developed for sole use with nurses and in nursing research. As well, the ECRS does not assess nurse and patient interactions or perceived responses by patients toward the nurse and patient clinical encounter (Yu & Kirk, 2009). Evidence of a theoretical perspective or an operational definition that guided the development of the ECRS were not found by this researcher. This researcher determined that the ECRS would not be appropriate for the proposed study because of its length and limited ability to capture patient perceptions of the nurse-patient clinical encounter.

Layton Empathy Test [LET]. This instrument was developed by Layton (1979) and consists of two forms. Both forms are comprised of three parts that assess the cognitive and behavioral domains of empathy (Yu & Kirk, 2009). The LET was developed for use with nursing students and to evaluate the use of role modeling empathy as a teaching strategy (La Monica, 1990). Content validity was determined by nursing faculty experts. Content validity was low (note: no P value was reported), and the reliability of the LET was also low at r = 0.24 to 0.26 (Yu & Kirk, 2009). This researcher evaluated that the LET is inappropriate for use in the proposed study because it was developed to evaluate a strategy to teach empathy. As well, the LET does not have strong psychometric properties, and does not measure the patient's perspective of nurse empathy that is the focus of the proposed study.

Perception of Empathy Inventory [PEI]. This tool was developed by Wheeler (1990) and consists of a 4- point scale comprised of 33 true and false questions to assess patient perception of nursing empathy in the behavioral domain of empathy (Yu & Kirk, 2009). Wheeler (1990) used the conceptual framework of Barrett-Lennard's (1981) on the phases of empathy to

develop this tool. Phase one involves the individual potential for empathy. Phase two identifies if empathy has been expressed and Phase three reflects whether empathy has been perceived to have been received (Strickland & Dilorio, 2003). The PEI was developed to measure Phase 3. Construct validity for this tool has been reported as r = -.52. Reliability was excellent with a Cronbach's alpha reliability estimate of 0.94 (Strickland, & Dilorio, 2003). This tool does not adequately reflect the purpose of this study.

Reynolds Empathy Scale [RES]. The RES is a 12-item, 7-point rating scale that was developed by Reynolds (2000) to capture the patient's perception of ineffective and effective empathy-related behaviours (behavioral domain) between the patient and the nurse (Yu & Kirk, 2009). Concurrent validity was r = 0.85, and the Cronbach's alpha reliability estimate ranged from 0.68 to 0.90 among nursing students (Yu, & Kirk, 2009). The RES was developed for use in nurse training programs to evaluate changes in empathic scores. This tool was not appropriate to capture both the nurse's perception of empathy and the patient's perception of nurse empathy.

Visual Analogue Scale [VAS]. This test was developed by Wheeler (1996) as a means to assess the teacher's perceptions of nursing student's empathic abilities in the behavioral domain of empathy (Yu, & Kirk, 2009). The VAS has not been tested comprehensively. Furthermore, concurrent validity was low (r=0.26) when correlated with the Layton Empathy Test. The Cronbach's alpha reliability estimate was 0.68 among nursing students (Yu & Kirk, 2009). This tool is not suitable for the proposed project as it was developed for educational use by a teacher-evaluator of only empathic behaviours by nursing students.

Of the aforementioned tools critiqued by this researcher, and Yu and Kirk (2009), only the RES and PEI were developed to capture the patient's perspective of nurse empathy. None of the tools discussed here have been developed to capture perspectives from nurses and patients

about nurse empathy. Yu and Kirk (2008; 2009) concluded from their review of empathy measures that there are inconsistent findings on how empathy was measured in previous studies. These authors also found variations in study quality. They included: a range of different instruments were used to measure empathy with nurses and nursing students, the variability in nurse characteristics that were examined, and the researchers employed a range of strategies to administer empathy tools. There remains a need for more rigorous evaluation of psychometric properties of empathy tools for use with nurses and nursing students.

Consultation and Relational Empathy [CARE]. Apart from the noted tools evaluated by Yu and Kirk (2008; 2009) the Consultation and Relational Empathy (CARE) Measure was reviewed by the researcher as a potential measure of nurse empathy from the perspective of both the nurse and patient. This tool consists of 10 items rated on a 5-item scale that takes less than 10 minutes to complete. CARE has been widely used as a patient assessment measure of the quality of the therapeutic patient-HCP consultation process from the patient's perspective (Mercer, Maxwell, Heaney, & Watt, 2004). CARE has high face and construct validity and internal reliability when assessing both physician and nurse encounters in the primary care setting (Bikker, Fitzpatrick, Murphy, & Stewert, 2015; Fitzgerald, Heywood, Bikker., & Mercer, 2014). The Cronbach's reliability coefficient for the tool is excellent (0.93) (Mercer et al., 2004).

Jefferson Scale of Physician Empathy [JSPE]. The researcher also assessed the Jefferson Scale of Physician Empathy [JSPE] Instrument which was also assessed by Yu and Kirk (2008; 2009). The JSPE consists of a 20 item, 7-point scale self-administering instrument and was developed in medical settings by a research team from the Center for Research in Medical Education and Health Care at Jefferson Medical College, which was led by Dr. M. Hojat at the Center for Research in Medical Education and Health Care, Jefferson Medical College in

the United States (Hojat, 2007). The tool was specifically developed to measure empathy among students and practitioners in the health care profession (Hojat, 2007). Dr. Hojat's (2007) team developed the Jefferson Scale with the intent of measuring the cognitive dimension of empathy and the behavioral dimension (the ability to communicate that understanding). The development of the JSPE was aligned with the above definition of empathy by Hojat (2007). It has since been established that the tool is sensitive to change and modified versions of the JSPE have been translated into 41 different languages for use with medical (Grossman et al., 2014) and nursing students (Ward, 2012, 2016), physicians (Hojat, 2007, 2009), nurses (Bourgault et al., 2015) and patients (Grossman et al., 2014; Hojat, 2007, 2009; McMillan & Shannon, 2011). The JSPE has good face validity (100 physicians, Delphi method) and convergent validity ($r = 0.12\text{-}\ 0.56\ p < 0.01$). Ward et al. (2012) reported psychometric data that supports the construct validity of the tool's use with medical students, residents, physicians, and nursing students where the Cronbach's alpha reliability estimates for the Jefferson Scale of Empathy-Health Providers (JSE-HP; health care provider version) ranged from 0.77 to 0.89 (Ward, 2012). Yu and Kirk (2008; 2009) similarly reported Cronbach's alpha reliability estimates for the tool's use across studies ranging from 0.87 0.89. It is important to indicate that the JSPE is also known as the Jefferson Scale of Empathy– Health Providers [JSE-HPs] tool (Ward, 2012).

Dr. Hojat's (2007) team determined that it was crucial to compare the patient's perception of the HCP's empathy and the HCP's self-report of empathy. A brief scale to measure the patient's perceptions of the HCP's empathic behaviour was developed and named the Patient's Perceptions of Physician Empathy [JSPPE] (Hojat, 2007). The JSPPE has good validity and a Cronbach's alpha reliability estimate of 0.91 (Grossman et al., 2014; Ward, 2012;). Correlations between each item of the JSPPPE and the American Board of Internal Medicine Patient Rating

form (Durning, Cation, & Jackson, 2003) ranged from 0.54 to 0.97 that suggested items of the JSPPPE were significantly related to physicians' communication skills, humanistic qualities, and professionalism (Kane, Gotto, Mangione, West, & Hojat, 2007). These findings provided evidence to support the validity of the items on the JSPPPE. Kane et al. (2007) concluded that the JSPPPE demonstrated good psychometric characteristics for assessing the HCP's empathy from the patient's perspective. These authors also described that adapting the JSPPPE for use with other health care professionals, including nurses, to capture self-reports of empathy did not weaken the reliability, or validity of the scales.

More recently, the development of the Scale Residents Perception of Own Empathy (SRPOE) was developed as a shortened version of the original Jefferson Scale of Empathy (Grossman et al., 2014). Grossman et al. (2014) evaluated the reliability of the JSPPPE and the SRPOE with residents and standardized patients. These researchers reported Cronbach's alpha reliability estimates of 0.86 for the Jefferson Scale of Empathy (JSE-HP); 0.91 for the Jefferson Scale of Patient Perceptions of Physician Empathy [JSPPPE]; and 0.94 for the Scale of Resident Perception of Own Empathy [SRPOE]. This evidence suggested to the researcher that the Jefferson Scale of Physician Empathy and the Jefferson Scale of Patient Perception of Physician Empathy are reliable tools to measure empathy. The shortened version of the original JSE tool, the Scale of Resident Perception of Own Empathy, is also an acceptable tool.

In summary, this researcher appraised common empathy tools on the basis of the following criteria: a) multidimensional nature of the tool; b) reliability and validity properties of the tool; and, c) appropriateness of the tool to capture nurse and patient perceptions of nurse empathy during clinical encounters. Based on a critical appraisal of these tools, this researcher determined that the Jefferson Scale of Empathy (JSE – HP) tool provides an excellent foundation

as an appropriate and sound multidimensional tool. The adaptation of the tool to the Scale of Resident Perception of Own Empathy (SRPOE) to compare with the patient version of the tool (JSPPE) provides this researcher with three valid tools to use in the research study.

Reliability of Self-Reports of Nurse Empathy

There are few nursing studies that have investigated the reliability of self-reported empathic behaviours by nurses. Studies that compared self-report of empathy by nurses with patient's perceptions of nurse empathy were not found by this researcher. Most studies tended to conduct a uni-dimensional examination of either the nursing student's or post-graduate nurse's empathy over time (Bourgault et al., 2015; Ward et al., 2012, 2016).

In related medical literature, Grossman et al. (2014) studied residents' self-reported empathy using the Jefferson Scale of Empathy (JSE-HP) and the modified Scale of Resident Perception of Own Empathy (SRPOE). The authors found moderate correlations between residents' self-reported empathy scores on both tools that reinforced the validity of the SRPOE. The authors then compared residents' self-reports of empathy on the SRPOE tool with standardized patients' [SP's] (i.e., trained individuals acting as patients) perceptions of residents' empathy on the Jefferson Scale of Patient Perception of Physician Empathy (JSPPPE). They reported no or poor correlations between residents' self-report and standardized patients' reports of residents' empathy scores. In other words, standardized patients did not agree with residents on the degree of empathy residents felt they demonstrated during their clinical encounters with standardized patients. These findings are consistent with Berg, Majdan, Berg, Veloski and Hojat's (2011) study where they found a poor correlation between third year medical students and standardized patients on medical student empathy. Similarly, Ogle, Busnell and Caputi (2013) found no association between observer-assessed empathy and standardized patient

assessment of residents' empathy as captured on the JSPPPE tool. Therefore, one can question whether the health care provider can provide reliable self-reports on empathic communication. It is likely that self-reports of empathy by HCPs are a measure of how they would like to communicate rather than how they actually engaged in empathic communication (Grossman et al, 2014). Also, each above mentioned study was conducted using 'standardized patients' (SP). A Standardized Patient is a person trained to portray, in a consistent, standardized manner, a patient in a medical situation (Ballman, Garritano, & Beery, 2016). SP's are used to aid in the development of cultural competency, interpersonal interactions, communication skills, and in interprofessional context. The SP provides feedback to the researcher based on the interaction observed in the clinical encounter set up by the researcher (Ballman et al., 2016).

In summary, this review of the literature did not result in locating studies that systematically examined the reliability of nurse self-reports of empathy in clinical practice. However, related studies with other HCPs (physicians or residents), provided evidence that HCP self-reports of empathic behaviour correlate poorly with standardized patient (SP) reports of HCP empathy. Further research that includes a comparison between nurse and patient perceptions of nurse empathy can offer a more accurate understanding of the degree of nurse empathy that is evident and experienced by actual patients in the clinical practice setting.

Summary

To summarize, this researcher conducted a review of the empathy literature that included a description of how empathy 'fits' within the current movement of health care towards patient-centered care and how health care organizations need to support empathy in clinical practice. Evidence indicates that how empathy is defined across studies has been inconsistent and primarily related to different dimensions of empathy that have been examined (i.e., cognitive,

affective, or behavioral). Individual-and system-level factors that pose as barriers for nurses to harness empathy in clinical encounters were also identified. In response to these barriers, investigators continue to develop and test interventions to promote empathy in nursing students and nurses in basic and continuing education. Nonetheless, this researcher identified a key gap in our knowledge on the degree of nurse empathy that exists in clinical encounters between nurses and actual patients. Based on this researcher's review of empathy tools, it was determined that the JSPPNE and the SNPOE are appropriate for comparing nurse self-reports and patient's assessments of nurse empathy in a busy ambulatory care setting.

Further research is required to contribute toward our knowledge of clinical areas where nurse empathy 'is' and 'is not' being experienced by patients. Evidence arising from such research can make important contributions toward knowing which clinic areas require attention to support nurse empathy and bolster patient trust in empathic nurse-patient clinical encounters where patients' needs are understood and met. Supporting empathy in nursing benefits not only patients and their families but also enhances the wellbeing and job satisfaction of nurses.

Chapter Three – Methodology

Given the paucity of research investigating how nurses and patients compare on their perceptions of the empathic approach taken by nurses in the out-patient clinic setting, a comparative descriptive study was determined to be the most appropriate type of investigation to pursue. This chapter explains the research design and methodology employed in this study. The research design, sample, setting, data collection method, and instrumentation are described in the following sections. In addition, ethical considerations are discussed.

Purpose of the Study

The purpose of this study is to describe how ambulatory clients and nurses compare in their perceptions of the nurse's empathy during outpatient clinical encounters.

Research Design and Method

This study was conducted using a comparative descriptive design. The study investigated the differences between nurse perceptions of their empathic approach during outpatient clinical encounters with patients and the perception of nurse empathy experienced by the patient. The study site was chosen for its availability of cardiac outpatient clinics that are staffed mainly by Nurse II, III, IV and V level nurses. A small qualitative component was employed to elucidate nurse participants' perceptions of barriers and facilitators toward the empathic approach taken by nurses in the clinical encounter.

Research Questions

The following questions were addressed in this descriptive comparative study:

<u>Quantitative Component</u>

1. What are ambulatory patients' perceptions of the empathic approach of nurses in the outpatient cardiac clinic? (descriptive question)

2. What are nurses' perceptions of their empathic approach in the outpatient cardiac clinic? (descriptive question)
3. How do the patients' and nurses' perceptions of the empathic approach of nurses compare in the outpatient cardiac clinic? (comparative question)
4. What nurse characteristics are linked to their empathic approach taken in the out-patient cardiac clinical setting?
5. What patient characteristics are linked to their perceptions of their nurse's empathic approach in the out-patient clinical setting?

Qualitative Component

6. What circumstances make it easier for you (registered nurse) to engage in empathic care with patients in the outpatient cardiac clinic? (Qualitative – Nurse)
7. What circumstances make it harder for you (registered nurse) to engage in empathic care with patients in the outpatient cardiac clinic? (Qualitative – Nurse)

Protection of Human Rights

Written ethical approval from the Education and Nursing Ethics Review Board at the University of Manitoba and written access approval from the urban hospital Research Review Committee (RRC) were obtained prior to commencing recruitment and data collection. The study was conducted in accordance with regulations in the Personal Health Information Act [PHIA] (Manitoba Law, 2016). Prior to signing the voluntary written consent, participants were provided with written procedural information. Potential participants were provided with a verbal explanation about the study, including risks and benefits associated with participating in the study. An opportunity to ask questions of this researcher was provided to participants who wished to address concerns associated with their role in the study. All information will be kept

confidential as real names of nurses and patients were not identified on study materials. Participants were advised not to write their names or any of the study material. Instead, participants' study questionnaires were assigned a code number. The master list that links participant names and assigned codes has been stored in a separate, locked filing cabinet in the researcher's home office. Only the researcher has access to participants' names. The researcher will ensure that participant' signed informed consent forms and completed questionnaires are secure in the researcher's home office. Seven years after the completion of the study, the data will be destroyed via confidential waste. Once the study is completed, all data on the researcher's personal computer will be destroyed.

The informed consent letter provided contact information for the researcher, the thesis supervisor, and the Human Ethics Coordinator. A second copy of the consent form was provided to participants for their records. Participants were informed in the informed consent form of their right to confidentiality and privacy, as well as how this right will be protected by the researcher. Participants were also informed that any information they provide will be presented as "grouped" data in written reports and in any publications of findings arising from this study. There was no deception of coercion associated with any of the study procedures. Nurses and patients were not compensated in any way for their participation in the study. In the event that the patient or nurse experienced personal distress arising from the study, the researcher had made provision for accessing a counselling resource. However, this service was not needed during, or post data collection.

Sample and Setting

A non-probability convenience sample included all registered nurses who were employed in the cardiac care outpatient clinics at one local, tertiary care hospital in Winnipeg and who had

direct contact with patients during the data collection time period. Registered nurse employment classification included Nurse II (staff nurse), Nurse III (Clinical Nurse Specialist (CNS) or educator, Nurse IV (Coordinator), and Nurse V (Advanced Practice Nurse/Nurse Practitioner). All registered ambulatory patients who meet the inclusion criteria, and who attended the cardiac outpatient clinics on the days the researcher was available in the clinic were invited to participate in the study.

Inclusion criteria for nurses included: (1) must be a registered nurse (RN). Inclusion criteria for patients establishes that they must be: (1) 18 years of age or over; (2) fluent in understanding, reading, and writing the English language; (3) cognitively competent to give informed consent; and (4) able to respond to empathy-related questions about a clinical encounter they had with a nurse while in the cardiac care clinic that day (Appendix C).

Feasibility of recruitment and anticipated sample size. The eligible population of nurses for this study included 25 registered nurses who worked in eight cardiac clinics at the tertiary care hospital and engaged in clinical encounters with ambulatory cardiac patients. The researcher's aim was to approach all nurses to participate in the study with an anticipated sample size of 25 nurses. Recruitment of cardiac patients occurred at the same eight cardiac clinics over a two-week period, until the required number (25-75) of patients had been recruited. The aim was to compare nurse and patient perceptions of nurse empathy in a non-matched sample of patients and nurses. Nurse and patient group mean scores on the empathy tool will be tested for differences. It had been calculated that the minimum effect size needed to get at least 80% power of participants to detect differences between the two groups (Polit & Beck, 2012) would minimally be one nurse to one patient participant (25-25 ratio) to 25 nurses to 75 patient participants in response to respective research questions for the current study.

Participant Recruitment

All participants were sought from the Cardiac Sciences Program outpatient clinics in one Winnipeg tertiary care hospital. Written approval of support for this research project was provided by the Cardiac Sciences Program Director (email communication, Mr. Reid Love, August 5, 2016). Upon approval from the hospitals research review committee (RRC), all eligible participants (nurses and patients) were provided with a written letter of invitation to participate in the study and a copy of the informed consent form.

The recruitment of patients occurred prior to nurse recruitment. The reception clerk was provided with a copy of the eligibility criteria for cardiac care patients (Appendix C). Upon arrival in the cardiac care clinic, the reception clerk gave each eligible participant a written invitation to participate in the study (Appendix D). Patients interested in speaking with this researcher further about the study were directed to the researcher who occupied a private room in the clinic. This recruitment protocol for nurses and patients had received written approval from the Cardiac Sciences Program Director and the Urban Hospital Research Review Committee.

To recruit nurses, this researcher provided a letter of invitation (Appendix E) to all eligible nurses working at the Cardiac Sciences outpatient clinics at the tertiary care hospital. The nurses were provided with an informed consent form (Appendix F) and the study questionnaires, including an envelope to insert the signed consent and completed surveys (Appendix G, H, I, J). Nurses were asked to then return completed study material to the researcher. Nurses were recruited immediately after patient recruitment was completed.

Data Collection

If patients agreed to speak to the researcher, they were directed to the private office space located in the clinic where the researcher was set up. The researcher introduced herself to patients and explained the study further to them. If the patient initially agreed to participate, the researcher reviewed the informed consent with patients while they are in the clinic. When written consent was obtained (Appendix K), the patient participant was instructed on how to complete the demographic survey (Appendix L) and the empathy questionnaire (JSPPNE) (Appendix M). The patient participants were asked to return the completed study questionnaires to this researcher who remained available in the clinic to answer any questions or concerns they might have had about the study questionnaires or their role in the study.

Nurse participants were provided with a package that contained a written invitation, an informed consent form, a demographic survey, and the two empathy-related questionnaires (JSE and the SNPOE). Nurse participants were also given instructions as to when to complete the one-time only study package. The drop box for returning the signed consent form, demographic survey, JSE and the SNPOE in the sealed envelope was located in the secure office area. Each envelope was coded in order to track the response. The nurse participants were instructed to not write their names on the study questionnaires or on the envelope, inside or out and to return the envelopes, sealed, in order to protect confidentiality. The surveys were retrieved by this researcher at a predetermined date.

Measurement Instruments

A total of five instruments were utilized in the study with nurse and patient participants.

Demographic questionnaires. The Nurse Demographic Questionnaire was a researcher-developed demographic data tool that captured the characteristics of the nurse for descriptive and

correlational analysis (described further below). Specific demographic questions captured nurse responses about their age, gender, number of years working as a nurse, number of years working as a cardiac nurse, occupational status, level of education, current employment status, and advanced training in communication skills (Appendix G).

The Patient Demographic Questionnaire was a researcher-developed demographic and medical information tool that captured patient characteristics about the patient including; patient age, gender, name of the clinic attended, amount of wait time spent in the clinic reception area, and if expected treatment was received (Appendix L). All medical information will be collected directly from the patient. Patients were not requested for written consent for the researcher to abstract their clinical medical charts.

Nurse empathy. To capture perceptions of nurse empathy, this researcher employed two empathy related questionnaires. The Jefferson Scale of Empathy – Nurse/Health Professions [JSE-HP] (Appendix H), The JSE-HP (nurse self-report) tool consists of 20 Likert-type questions, ranging on a scale of 1 (strongly disagree) to 7 (strongly agree) with a score range between 20 (low) and 140 (high). Cronbach's alpha reliability estimates for the JSE-HP were 0.86 (Grossman et al., 2014). The Scale of Nurses Perception of Own Empathy [SNPOE] (Appendix I) (i.e., adapted from the previously modified Scale of Residents' Perception of Own Empathy) was the second tool used in this study. The SNPOE contained modified items from the JSE-HP tool which included the substitution of the word 'Resident' for the 'Nurse'. The SNPOE (nurse self-report) consisted of five Likert type questions, also on a scale of 1 (strongly disagree) and 7 (strongly agree). The Cronbach's alpha reliability estimates are 0.94 for the Scale of Resident Perception of Own Empathy [SRPOE] reported by Grossman et al. (2014). The scoring

potential ranges from a low of 5 to a high of 35. The higher score would indicate greater nurse empathy.

The questions on the SNPOE (nurse self-report tool) are from the perspective of the nurse and include: (1) “I view things from the patient’s perspective [see things as he/she sees them]”; (2) ‘I ask what is happening in my patient’s daily life”; (3) “I am concerned about the patient and their family”; (4) “I understand the emotions, feelings and concerns of my patients”; and (5) “I am an understanding nurse” (Appendix I).

Patient perception of nurse empathy. To capture the patient participant perception of nurse empathy the researcher used the Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE) (Appendix M). The JSPPNE is a seven-point Likert-type scale survey with 1 being strongly disagree and 7 being strongly agree for a total score between 5 (low) and 35 (high). The higher the survey score would represent a higher patient perception of nurse empathy. Grossman et al. (2014) reported Cronbach’s alpha reliability estimate of 0.91 for the Jefferson Scale of Patient Perceptions of Physician Empathy [JSPPPE].

The questions on the JSPPNE were similar to the questions posed to nurses on the SNPOE to capture patient’s perspectives on nurse empathy: The nurse I saw in clinic today: (1) “viewed things from my perspective [saw things as I see them]”; (2) ‘asked what is happening in my daily life”; (3) “was concerned about the me and my family”; (4) “understood my emotions, feelings and concerns”; and (5) “was an understanding nurse”. The patients were asked to fill out this survey immediately following their clinical encounter with the nurse(s).

Response items from the all three tools used (above) included a seven-point Likert-type scale where ‘1’ indicates that respondents strongly disagree and ‘7’ indicating they strongly agree with the question. Scores can range from a low of ‘5’ to a high of ‘35’ on both the SNPOE and the

JSPPNE. Scores for the JSE-HP could range from a low of 20 to a high of 140. In each survey, the higher score would indicate greater nurse empathy.

This researcher sought permission to revise the wording of the Scale of Resident Perception of Own Empathy (SRPOE) to capture self-reports of nurse empathy, called the Scale of Nurse Perception of Own Empathy (SNPOE). The Jefferson Scale of Patient Perception of Physician Empathy (JSPPPE) has been revised, with permission, to capture the patient's perception of nurse empathy, called the Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE).

Further information about the JSE-HP can be found at:

http://www.jefferson.edu/university/skmc/research/research-medical-education/jefferson-scale-of-empathy.html

Nurse open-ended questionnaire. The researcher also developed a brief open-ended pen and paper questionnaire to employ with nurses to help them identify facilitators and barriers for them to engage in empathy in clinical encounters with patients. The questions included: 1) What circumstances make it easier for you to engage in empathic care with your patients in the outpatient cardiac clinic? 2) What circumstances make it harder for you to engage in empathic care with patients in the outpatient cardiac clinic? (Qualitative – Nurse) (Appendix J)

Data Analysis Plan

Data entry and analysis were conducted using the Software Package for Social Sciences – 24 (SPSS- Version 24). The following describes respective analyses employed to address Research Questions #1-4. To describe the reliability of the SNPOE and the JSPPNE, the researcher reported on the Cronbach's alpha coefficients. The Cronbach's alpha coefficient is the

most frequently utilized measure of reliability and internal consistency (Cronbach, 1951). For all tests, statistical significance will be set at *p*-value <0.05.

Inferential Analysis of Research Questions

To ensure that the most appropriate inferential testing occurred, this researcher consulted several times (December 15, 2016, January, 4, 2017, August 15, 2017 and September 14, 2017) with Dr. Rasheda Rabbani at the Manitoba Centre for Nursing and Health Research.

Quantitative Analysis

Research question #1. What are ambulatory patients' perceptions of the empathic approach of nurses in the outpatient cardiac clinic? (Descriptive question)

Research question #2. What are nurses' perceptions of their empathic approach in the outpatient cardiac clinic? (Descriptive question)

To describe the demographic characteristics of the sample and study variables to address research question #1(patient perception of nurse empathy) and #2 (nurse self-reports on empathy), frequencies, means, and standard deviations or means or ranges will be reported.

Research question #3. How do the patients' and nurses' perceptions of the empathic approach of nurses compare in the outpatient cardiac clinic? (Comparative question)

To analyze Likert-type responses captured on the SNPOE and the JSPPNE, an appropriate non-parametric test will be employed to test for non-paired group median differences on nurse empathy (e.g., Mann Whitney U test). With ordinal scales, it is the order of the values that is of interest but the difference between the values is not really known (Polit & Beck, 202). The participants' scores will also be correlated using appropriate non parametric Spearman's non-parametric Spearman's rank correlation coefficient analyses. The nurse and patient samples will have dependency with paired values between the nurse and patient.

Research question #4. What nurse characteristics are linked to their empathic approach taken in the out-patient cardiac clinic? (Comparative question)

To examine relationships between nurses self-reports on empathy and nurse characteristics, appropriate non-parametric or parametric tests of differences in groups (Mann-Whitney test, Kruskal-Walis test, t-test or ANOVA) or correlational analysis (parametric Pearson's *r* or non-parametric Spearman's *rhos*) will be employed depending on the level and distribution of data collected.

Research question #5. What patient characteristics are linked to their perceptions of their nurse's empathic approach in the out-patient cardiac clinic? (Comparative question)

To examine relationships between patient reports on nurse empathy and patient characteristics, appropriate non-parametric tests of differences in groups (Mann-Whitney test, Kruskal-Walis test, t-test or ANOVA) or correlational analysis (parametric Pearson's *r* or non-parametric spearman's *rhos*) will be employed depending on the level and distribution of data collected.

Qualitative Analysis

Research question # 6. What circumstances make it easier for you [registered nurse] to engage in empathic care with your patients in the outpatient cardiac clinic?

Research question #7. What circumstances make it harder for you [registered nurse]to engage in empathic care with patients in the outpatient cardiac clinic?

To augment quantitative responses captured on two nurse empathy tools (self-report and patient report), the researcher will pose two open-ended, pen-and-paper questions to nurses to describe perceived barriers and facilitators for nurse empathy during clinic encounters:

The content of nurses' responses to the open-ended pen and paper questions will be analyzed by the researcher and by the researcher's thesis committee members. Content analysis will be conducted with respect to describing nurses' perceptions of barriers and facilitators of their use of empathy with the patient in the ambulatory care setting. Content analysis is a method for analyzing the content of communications in a systematic and objective way (Munhall, 2012; Polit & Beck, 2012). The researcher and thesis committee members will engage in open coding and develop categories and themes as they emerge.

Trustworthiness of the content analysis will be addressed employing criteria by Lincoln and Guba (1981). Auditability will be addressed by the researcher who will plan to develop operational definitions for the code categories. Confirmability or maintain a degree of neutrality will be addressed by engaging the researcher's thesis committee members in coding the data and then determining whether they identify the same meaning units as the researcher.

Summary

To the best of this researcher's knowledge, there is a current paucity of empirical work that has examined how nurses and patients compare on their perceptions of the empathic approach taken by nurses in ambulatory care settings. A comparative descriptive study was determined to be the most appropriate type of investigation to address this gap in the literature about nurse empathy. Both quantitative and qualitative methods of data analyses were employed in this study. Descriptive statistics will be used to describe the overall sample characteristics and nurse empathy as rated by nurses and patients in varied ambulatory cardiac care clinics in one tertiary care hospital in a urban center. Internal consistency reliability of the empathy tools completed by nurses and patients was analyzed using Cronbach's alpha reliability estimates.

Appropriate parametric and/or non-parametric tests of differences and correlation coefficient analyses to determine: (1) how nurses and patients compare in their responses about nurse empathy and (2) linkages of nurse and patient characteristics with their perceptions of nurse empathy will be conducted. Content analysis of responses to open-ended questions about barriers and facilitators as perceived by nurses in the clinic was employed by this researcher. Criteria for trustworthiness of content analysis as guided by Lincoln and Guba (1981) will also be addressed by this researcher.

Chapter Four – Data Analysis

The main purpose of this study was to describe how patients and nurses in ambulatory cardiac care out-patient clinics compare in their perceptions of nurse empathy during clinical encounters. The research questions were:

Quantitative Questions:

1. What are ambulatory patients' perceptions of the empathic approach of nurses in the outpatient cardiac clinic? (descriptive question)
2. What are nurses' perceptions of their empathic approach in the outpatient cardiac clinic? (descriptive question)
3. How do the patients' and nurses' perceptions of the empathic approach of nurses compare in the outpatient cardiac clinic? (comparative question)
4. What nurse characteristics are linked to their empathic approach taken in the out-patient cardiac clinic?
5. What patient characteristics are linked to their perceptions of their nurse's empathic approach in the out-patient cardiac clinic?

Qualitative Questions:

6. What circumstances make it easier for you [a registered nurse] to engage in empathic care with patients in the outpatient cardiac clinic? (Nurse)
7. What circumstances make it harder for you [a registered nurse] to engage in empathic care with patients in the outpatient cardiac clinic? (Nurse)

This chapter describes the data collection protocol, the characteristics of the patient and nurse participants, the results of descriptive and inferential analyses in response to the research questions, and the reliability of the study instruments used with each nurse and patient

participant. Statistical analyses of the research questions are presented in conjunction with a report of the major findings. The significance level of $p < 0.05$ was set for all tests. IBM SPSS version 24 was employed to conduct all statistical analyses. Patient data for this study were collected between June 15 and June 29, 2017. Nurse data were collected between July 3 and July 16, 2017. The site recruitment site included cardiac clinics at one tertiary hospital in an urban Canadian hospital. Data was collected from the participants by employing a patient and nurse version of a researcher-developed demographic survey. Nurse participants completed the Jefferson Scale of Empathy – Health Care Provider (JSE-HP) and the Scale Nurse Perception of Own Empathy (SNPOE). Patient participants completed the Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE). Patients were invited to participate in data collection after their visit with the clinic nurse. Nurses were invited to participate within two weeks following the collection of data from the patients. All nurses, (Nurse II, III, IV, and V) were invited to participate in the study who had provided direct care to at least one patient who agreed to participate in the survey.

Data collected on the questionnaires were entered into the computer file by the researcher.

Profile of Participants and Data Collection Protocol

Response rate of patients. The letter of invitation was provided by the registration clerks to a convenience sample of 106 patients attending the cardiac clinics. Thirty-six patients agreed to participate in the study. Of note, seven of the 36 patient participants completed two Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE) tools because they were seen by two different classification of nurses for

different assessments or treatments during their same day clinic visit, for a total of 43 completed JSPPNE surveys. The patient response rate was calculated at 33.96% (36 of 106 patients). Seventy patients were not surveyed because they refused the invitation to participate. Reasons for refusal included increased wait times and patient anxiety about their time remaining on the parking meter, this information was relayed to the researcher by the registration clerk. All patients who agreed to participate met the inclusion criteria and were enrolled in the study.

Response rate of nurses. A clinic manager placed letters of invitation and the study package consisting of the consent form and study surveys in eligible nurses' mail boxes or they provided study materials directly to eligible nurses. Of note, the clinic manager was not necessarily the one who worked in the same clinic as eligible nurse participants. Twenty-five eligible nurses were invited to participate in the study. The nurses were verified by the researcher as having direct contact with patient participants who agreed to participate in the study. Nurse participants were provided written instructions to complete and return their signed informed consent and study surveys in the envelope provided by the researcher. The instructions clearly stated to seal the envelope in order to protect the nurse participant's confidentiality.

Of 17 surveys returned in their sealed envelopes, one survey had missing information and no signed consent form and four additional surveys were returned 'blank". Eight surveys were not returned. Twelve consent forms and surveys were completed by 12 nurse participants, for a response rate of 48% (12 of 25 nurses). It is interesting to note that there were no signed consent forms and completed surveys returned by NURS V nurses. Thirteen nurses were considered non-participants as indicated in Table 1 below.

Table 1
Reasons for non-participation of nurses (n=13)

Reason for non-participation	Number of eligible nurses
A. Surveys not returned	Eight
B. Survey returned but consent was not signed	One
C. Surveys returned in the sealed envelope but were not completed	Four

Prior to commencing the data collection protocol, the researcher provided eligible patients with the informed consent form to read (Appendix K). Once the patients had read, understood, and signed the consent form, they were invited to complete the JSPPNE and the Demographic Survey in a private area of the clinic assigned to the researcher. The surveys were then coded by the researcher to match the pre-assigned code number on the consent form. Signed and coded consent forms of patients were securely locked in a filing cabinet in the researcher's home office. No master list of codes assigned to participants was created.

Eligible nurse participants, from eight clinics were provided with an envelope, a letter of invitation, the consent form, two nurse empathy surveys (JSE-HP and the SNPOE), and the demographic survey. Written instructions were provided by the researcher on how to return the completed informed consent and study survey forms in a sealed envelope which was to be placed in the slot box located in a secure, non-clinical space, in the hospital.

Demographic Characteristics of Patients. A convenience sample of 36 patients participated in this study. Of the 36 patient participants, one was between the ages of 31 to 50 (2.8%, 1 male), 16 were between 51 to 70 years of age (44.4%, 11 male and five female) and 19 were over 70 years of age (52.8, 14 males and five females). Twenty patient participants were married (46.5%, 15 males and 5 females). Eight patients reported that they were widowed

(22.2%, four males and four females). Five males were never married (13.9%), two males reported they were in a common law relationship (5.6%), and one female identified that she was separated (2.8%). The average wait time to be seen by a nurse was 11.2 minutes, ranging from no wait time to one hour. All patient participants stated that they had received the treatment they expected. Further details are provided in Table 2.

Table 2
Characteristics of the Patient Participant (n = 36)

Characteristic	Patient Frequency (%)
Age	
31-50 years old	1 (02.8)
51-70 years old	16 (44.4)
70+ years old	19 (52.8)
Gender	
Male	26 (72.2)
Female	10 (27.8)
Marital Status	
Married	20 (55.6)
Common-Law	2 (05.6)
Never Married	5 (13.9)
Widowed	8 (22.2)
Separated	1 (02.8)
Minutes Waiting	
Zero minutes	4 (11.1)
4 minutes	1 (02.8)
5 minutes	12 (33.3)
10 minutes	8 (22.2)
15 minutes	4 (11.1)
20 minutes	4 (11.1)
30 minutes	2 (05.6)
60 minutes	1 (02.8)
Treatment Expected	
Yes	36 (100)

Demographic Characteristics of the Nurse Participant. A convenience sample of 12 nurses participated in this study. Nine were between 51 and 60 years of age (75%), and three were between 41 and 50 years of age (25%). One nurse reported that he or she had between 10 and 15 years of total nursing experience with five years of cardiac nursing experience (8.3%),

one reported having >35 years of total nursing experience (8.3%) which included 20 years of cardiac experience, ten (83.3%) reported that they had between 20 and less than 35 years of total nursing experience. There was a mean average of 21.7 years of cardiac experience among the 12 nurse participants. There was a mean total of 20.2 years of experience in the current cardiac program for 12 nurse participants. Seven nurses (58.3%), were classified at a Nurse II level, 4 nurses (33.3%) at a Nurse III level and one nurse (8.3%) at a Nurse IV level. Five nurses (41.7%) had a registered nursing (RN) diploma obtained from a hospital program, four (33.3%) had a with a RN diploma obtained from a college program, and three (25%) held a RN Bachelor Degree from a university program. Five nurses (41.7%) worked full time, and seven nurses worked part-time (58.3%). Four (33.3%) nurses stated that they had received advanced training in communication, three (25%) received empathy training and two (16.7%) received training in advanced patient centered care. Further details are provided in Table 3.

Table 3
Characteristics of nurse participants (n = 12)

Characteristics	Nurse Frequency (%)
Age	
41-50 years old	3 (25)
51-60 years old	9 (75)
Gender	
Female	12 (100)
Nurse Level	
Nurse II	7 (58.3)
Nurse III	4 (33.3)
Nurse IV	1 (8.3)
Nurse V	0 (0)
Education Level	
Hospital Diploma	5 (41.7)
College Diploma	4 (33.3)

Bachelor Degree (Nursing)	3 (25.0)
Years' Experience Worked (Nurse)	
>10 to 20	1(8.3)
>20 to <35	10(83.3)
35+	1(8.3)
Years' Experience in Cardiac	
5-33 years (M = 20.2)	N/A
Work status in Cardiac	
Full Time	5 (41.7)
Part Time	7 (58.3)
Advanced Training in Communication	
Yes	4 (33.3)
No	8 (66.7)
Advanced Training in Empathy	
Yes	3 (25)
No	9 (75)
Advanced Training in Patient-Centered Care	
Yes	2 (16.7)
No	9 (75)
No response	1 (8.3)

Instrument Reliability

Internal consistency reliability of the JSE-HP, SNPOE, and the JSPPNE tools, were calculated for the patient and nurse participant groups using Cronbach's coefficient alpha. The criterion for adequate reliability was established as alpha > .70 (Beck & Polit, 2012). Evidence for the internal consistence reliability of each scale in the current study was: 0.51 for the JSE-HP (20 item nurse self-report), 0.79 for the SNPOE (five-item nurse self-report), and 0.89 for the JSPPNE (five-item patient-report).

Concurrent Validity of the SNPOE Tool

To evaluate the current validity of the five item SNPOE, the SNPOE was correlated with the 20 item JSE-HP scale using Pearson Correlation (2-tailed). There was a positive correlation between the two variables, r (12) = .73, p = 0.007.

The positive correlation between the JSE-HP, and the SNPOE tool provided concurrent validity for the SNPOE tool. The SNPOE tools was employed to compare its score (nurse self-report on nurse empathy) with the score on the JSPPNE (patient report on nurse empathy).

Normality of Data Distribution

Using the Shapiro-Wilk test of Normality, the *p* value for the SNPOE total score was 0.89, which indicated that nurse data were normally distributed. On the other hand, the *p* value of >.0.01 for the JSPPNE total score indicated that patient data were not normally distributed.

Analysis of the Research Questions

Quantitative Research Questions

The following quantitative research questions were addressed. Patient and nurse participants were asked to rate their perception of nurse empathy on 7-point Likert-type scale, with "1" being strongly disagree and "7" being strongly agree. The patient and nurse participant scores on the Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE) and the Scale of Nurse Perception of Own Empathy (SNPOE) are respectively reported in response to Research Questions #1 and 2 as follows:

Research Question 1. What are ambulatory patients' perceptions of the empathic approach of nurses in the outpatient cardiac clinic? (Descriptive question)

The average total (JSPPNE) score for patients was 25.14 (s.d. 8.25) as displayed in Table Three. The highest mean item score was 5.67 (s.d. 1.92) for question five "Was an understanding nurse" and the lowest mean item score was 4.33 (s.d. 2.21) for question four "Asked what is happening in my life". The total mean score across five questions on the JSPPNE was 25.14 (s.d. 8.26). The total median score was 29.

Research Question 2. What are nurses' perceptions of their empathic approach in the outpatient cardiac clinic? (Descriptive question)

The average total on the Scale of Nurse Perception of Own Empathy SNPOE) score for nurses was 29.75 (s.d. 3.10) as displayed in Table Three. The highest mean item score was 6.58 (s.d. 0.67) for question three "I am concerned about my patient and their family" and the lowest mean item score was 5.33 (s.d. 0.98) for question one "I view things from my patient's perspective". The total mean item score across five questions on the SNPOE was 29.75 (s.d. = 3.10). The total median score was 29.5. (see Table 4)

Table 4
Patient and Nurse Responses on Nurse Empathy on the JSPPNE and SNPOE

	Patient (n = 43)		**Nurse (n = 12)**		
Question	Mean (s.d.) Score	Median Score	Mean (s.d) Score	Median Score	Mann-Whitney U test p-value
1.Viewed/I view things from my/my patient's perspective	5.21 (1.86)	6.0	5.33(0.98)	5.0	p =.56
2.Ask what is happening in (patient) life	4.33(2.21)	5.0	5.96(0.92)	6.0	p =.037*
3.Seemed concerned about me and my family/patient and family	4.79(1.98)	5.0	6.58(0.67)	7.0	p =.003*
4.Understood (my/patient) emotions, feelings and concerns	5.14(1.85)	6.0	5.42(0.97)	5.0	p =.93
5.Was (I am) an understanding nurse	5.67(1.92)	7	6.46(0.58)	6.5	p= .05
Total Score	25.14(8.26)	29	29.75(3.10)	29.5	p=.10

*Denotes actual p-values that indicate where significant differences existed using the *Mann-Whitney U-test.* Significance level is $p < .05$.

Research Question 3. How do the patients' and nurses' perceptions of the empathic approach of nurses compare in the outpatient cardiac clinic? (Comparative question)

Based on the non-normal distribution of the JSPPNE total score data (patient report of nurse empathy) plus results of the Levene's test for equality of variance, a decision was made to use the non-parametric Mann-Whitney U test to examine whether differences in nurse empathy ratings (ordinal data) existed between patients and nurses on the total JSPPNE and SNPOE scores.

For overall total scores on nurse empathy, a statistically significant difference was not found between nurse perception of their own empathy and the patients perception of nurse empathy (p = .10) (see Table 4). Statistically significant differences were found between nurse and patient responses on items two, and three, as captured on the SNPOE and the JSPNNE, respectively. Nurse responses on "asking what is happening in the patient's life" (Item #2) reflected higher scores than patients' scores (p = .037). Nurses' responses on their concerns "about the patient and their family" (Item #3), were also higher than the patients' reports (p = .003). Thus, nurses tended to perceive that they engaged in greater nurse empathy on several individual empathy items in comparison to patients' perceptions of nurse empathy experienced during their clinic encounter. A non-significant negative correlation was found when comparing strength and direction, between the JSPPNE and the SNPOE total scores r = -.28, p = .37, using the Spearman's Rank Order Correlation (r).

In summary, no significant difference was found between the total scores on nurse self-report and patient perception of nurse empathy. However, item two and item three had significant differences where nurses' higher empathy ratings in comparison to patients' ratings of nurse empathy on the same items.

Research Question 4. What patient characteristics are linked to their perceptions of their nurse's empathic approach in the out-patient clinical setting?

As guided by Davis's (1994) organization framework on empathy, this researcher examined patient characteristics as potential antecedent variables of patient's perceptions of nurse empathy. Relationships between patient perceptions of nurse empathy (captured on the JSPPNE) with numerous patient demographic variables were tested using non-parametric tests to detect sub-group differences and correlations.

Analysis, using the non-parametric Mann-Whitney U test, indicated that the age of the patient was a significant variable in conjunction with the total JSPPNE score. Patient participants who were between 51 to 70 years of age reported a significantly higher perception of nurse empathy then patients who were 70 years and older ($p = 0.016$).

There were no significant differences in patient gender, marital status, or wait room times on the patients' JSPPNE total score. Male and female patient participants did not report a statistically significant difference in their JSPPNE total scores ($p = 0.34$). For marital status analysis, two categories 'married and common law' and 'not married' were created based on collapsed data to protect the anonymity of the patient participants. No statistical difference was found between marital status mean group scores on JSPPNE ($p = 0.85$). As well, there was no significant correlational difference found between wait times and patient perceptions of nurse empathy using the Spearman rho, $p = 0.38$.

Overall, a significant difference was found where patients who were 70 years of age or older perceived lower nurse empathy than patient participants who were between 50 and 70 years of age. The variables of patient gender, and marital status, were not statistically significant in this

study. The length of time spent in the waiting room for the patients was also not significantly correlated with patients JSPPNE total scores.

Research Question # 5. What nurse characteristics are linked to their empathic approach taken in the out-patient cardiac clinical setting?

As guided by Davis's (1994) organizational framework on empathy, this researcher examined nurse characteristics as potential antecedent variables of their self-reports of nurse empathy. The relationship of nurse empathy captured on the SNPOE, with numerous nurse demographic variables were tested using parametric and non-parametric tests to detect sub-group differences and correlations.

Nurse characteristics that were examined included the age of the nurse, classification of nurse work level (NURS II, III, IV and V), the level of education, the number of years worked as a nurse, the number of years worked as a cardiac nurse, the part-time or full-time status, and advanced training in communication or patient-centered care were not significantly related to the nurses self-reports of empathy as reported on the SNPOE. Nurses between 41 to 50 years old [n = 3, M = 30(s.d. 1.0)] and 51 to 60 years old [n = 9, M= 29.67(s.d. 3.6)], using the independent t-test for two group means [$t(10) = .154$, $p = .89$] was not significant. The Mann-Whitney U test also confirmed that age did have a significant effect on nurse-empathy ($p = 0.73$). Using the One-way ANOVA test, no significant differences in nurse empathy scores were found among three Nurse Classification variables, Level II, III, or IV, [$F(2,9), = 3.04$, $p = 0.098$]. The years of experience as a nurse was not analyzed as there was little variability in the data that was reported.

Pearson's correlation coefficient was used to determine if a correlation existed between cardiac care work experience and nurse empathy scores as reported by the nurse. There was

no significant correlation [n = 12, r =.25, p = 0.43] found. There was also no statistically significant difference reported using the independent t-test in nurse empathy between nurses who were employed full time [n = 5, M = 28 (s.d. 1.58)] and those who were employed part-time [n = 7, M = 31(s.d. 3.42)] on the SNPOE [t (10) = -.81, p = 1.0]. The Mann-Whitney U test significance level was also non-significant (p = 0.73).

The Mann-Whitney U test was also not significant on nurse participants who were trained in a diploma or a degree program (p = .21).

There were no significant difference found between the empathy scores of nurses who received advanced training or education in communication [n = 4, M=32(3.17)] and those who did not [n=8, M = 28.62(s.d 2.56)]; t (10) = 2.0, p = 0.73 as reported on the independent t-test. The Mann-Whitney U test confirmed no significant difference in empathy scores of nurses who received advanced training or education in communication (p = 0.11). There was also no significant difference in empathy scores for nurses who received advanced training or education in patient-centered care [n=2, M = 30(s.d. 0.07)] and those who did not [n= 7, 29.2 (s.d. 2.12)]; t (9) = 0.323, p = 0.90. The Mann-Whitney U-test confirmed that there was no significant difference between the two group variables (p = 0.42).

There was a significant effect for advanced training or continuing education in empathy or compassion skills on SNPOE scores where nurses with training in empathy or compassion [n=3, M = 33.3(s.d. 2.1) versus those who did not have training in empathy or compassion [n=9, M = 28.56(s.d.2.4)]; t (10) = 3.1, p = 0.12 reported higher empathy scores on the SNOPE. The Mann-Whitney U test also revealed a significant difference (p = 0.02).

In summary, nurses who had received advanced training or continuing education in empathy or compassion skills reported significantly higher scores on the SNPOE than the nurses

who did not have advanced training or continuing education on empathy skills. Nurse characteristics such as the number of years worked as a nurse, the number of years of cardiac work experience, part-time or full-time work status, between nurse participants who were educated through a diploma or degree program, and advanced training in communication or patient-centred care did not impact nurse reports on self-empathy.

Qualitative Research Questions

The following qualitative research questions were addressed.

Research Question # 6. What circumstances make it easier for you (registered nurse) to engage in empathic care with patients in the outpatient cardiac clinic?

Research Question #7. What circumstances make it harder for you (registered nurse) to engage in empathic care with patients in the outpatient cardiac clinics?

Eleven of the 12 nurse participants responded to the open-ended questions provided in the survey. The content of each of nurses' responses to the open-ended questions were content analyzed by the researcher. In order to promote trustworthiness in the content analysis, confirmability or maintaining a degree of neutrality was addressed by engaging the researcher's thesis supervisor (Dr. Michele Lobchuk) in coding five nurse responses, and then comparing codes with this researcher for coding accuracy. Trustworthiness of the content analysis was addressed using Lincoln and Guba's (1981) criteria. Auditability was addressed by the researcher and Dr. Lobchuk who developed operational definitions for the coding template. The researcher adapted this coding template to complete coding with all of the remaining nurse responses to questions six and seven on the survey.

For question six, "What circumstances make it easier for you (registered nurse) to engage in empathic care with patients in the outpatient cardiac clinics?", five code categories with seven

sub-codes were identified from nurses' responses. For question seven, "What circumstances make it harder for you (registered nurse) to engage in empathic care with patients in the outpatient cardiac clinics?", seven code categories (codes) including 14 sub-codes were identified. These categories were determined based on this researcher's interpretation of responses by nursing staff in the ambulatory cardiac care setting. The operational definitions of the cue categories used to reflect barriers that impacted nurse empathy are provided in Tables Four to Six (Appendix N, O, and P)

Due to the similarity in nurse response, this researcher combined nurse responses to Research Questions #6 and #7. The following is a brief report on the four major themes and their respective definitions and illustrative quotations.

Themes

Four themes were identified from open-ended question responses to the researcher's script of interview questions to address Research Questions #six and seven. The four major themes were: 1) Constrained time limits listening and engagement; 2) Challenging patient – nurse interactions impact empathy; 3) A complex, demanding care environment; and 4) Need for a leadership culture that supports empathy.

Theme one – Constrained time limits listening and engagement. Theme one, *Constrained time limits listening and engagement* reflects nurse statements about the time required by nurses to engage in the empathic care of patients as impacted by unexpected circumstances or difficult situations in the clinic setting. Seven of the nurse participants responded that time was a major factor that impacted their ability to provide empathic care in the clinic setting. Several nurse participants responded as follows that they needed more time to engage with, hear, and listen to the patient:

"Time with my patient to hear their personal story and to connect" (Participant 1)

"Having time to listen." (Participant 4)

"Having time to engage in a conversation as I provide care" (Participant3).

"Time given to have themselves heard and understood" (Participant 5)

Other nurse participants, were concerned about unforeseen or unexpected circumstances that can occur which impacted their ability to engage in an empathic approach:

"Time can be a factor if unforeseen circumstances arise. It becomes difficult to be fair to all patients in the clinic area when some need extra time." (Participant 3).

"When dealing with difficult situations or potentially explosive one" (Participant 3)

However, one nurse argued that if more time is needed for the patient then this decision was the nurses to determine:

"We are a busy, time oriented clinic should a patient need my time, for me it is mine to give not always but if needed so be it" (Participant 5)

Theme two - Challenging patient – nurse interactions impact empathy.

Theme two, *Challenging patient – nurse interactions impact empathy*, reflects nurse statements about challenges encountered when dealing with behaviours and characteristics of patients that thwart their ability to engage in empathic care. Eight of the nurse respondents stated that they felt that patient characteristics and behaviours made it more difficult (or easier) to provide empathic care. Some nurse participants described the following as barriers to empathic care:

"Their ability to hear" (Participants 4, 6 and 9)

"When there is no language barrier" (Participant 9)

Three nurses suggested that past experiences, particularly those that were unfavorable with health care, was a barrier to empathic care:

> "Bad experience by either themselves or someone they know" (Participant 11)
>
> "Patients that have experienced a breach in trust (e.g. disrespect, incompetence) with previous medical encounter are more closed down and skeptical towards an understanding, competent encounter" (Participant 2)
>
> "Past experience with health care professionals" (Participant 10)

Two nurses were concerned about patients who had a negative attitude and were angry:

> "Patients bad attitude or anger misdirected at me" (Participant 11)
>
> "An angry patient can make it more difficult to engage in empathic care" (Participant 5)

The remaining barriers as reported by nurses, included interruptive families that made it difficult for the nurse to engage in empathic care toward these families. Another nurse described the challenges of dealing with the high acuity of patients who have a lot of needs that detract from nurse engagement in empathic care.

Theme three – A complex, demanding care environment. Theme three, *a complex demanding care environment,* reflects nurse statements about the work environment and its effect on their ability to provide empathic care to the patient. Two nurses reported that privacy was important for the development of empathic care in the clinic setting.

> "Having a private space for history taking" (Participant 12)
>
> "One on one in the office allows for privacy and open about their feelings and discuss family and personal situations" (Participant 11)

Other nurse participants reported that a busy clinic makes it difficult to engage in empathic care:

> "Busy clinic" (Participant 4)

> "When I am not rushed during a patient assessment and when I see several patients in the waiting room that need to be seen makes the 1:1 difficult because you know another patient needs to be seen" (Participant 7)

Two nurses discussed the need for continuity of care that reflects the benefits of seeing patients more frequently and consistently to develop a relationship:

> "When I see the patients more than once or for a longer visit" (Participant 9)
>
> "Continuity of care. Developing a relationship with the patient establishing trust and confidence." (Participant 10)

Finally, not found on the open-ended questionnaires but written in the margins of a JSE-HP questionnaire on nurse empathy, a nurse wrote "I try to".

Theme Four – Need for a leadership culture that supports empathy. Theme four, *Need for a leadership culture that supports empathy*, captures nurse statements about other nurses, nurse managers and other health care professionals in support of their empathic care provided in the clinical setting. Two nurses commented on nursing staff shortages in the clinics as a circumstance that affects empathic care.

One nurse reported that patients are not adequately prepared for their appointments by other nurses who are responsible for this preparation. Another nurse described that communication between nurses needs to improve for empathic care to be given. These nurses stated:

> "Are when a patient isn't properly prepped for the appointment this slows the appointment down not allowing for time to engage." (Participant 5)
>
> "Having adequate communication amongst nurses" (Participant 4)

One nurse summed up her position on circumstances that would make it easier [or more difficult] to provide empathic care by stating that it is nurse managers and leaders who have a major role in encouraging empathic care in the clinical setting.

> "If someone is complicated and I take additional time to support the patient, I often have to stay overtime or miss my lunch break. Taking extra time is not encouraged because our department is already short staffed. Being open to acknowledge the patients as a whole person, understanding that their medical issue may be affected by other factors in their lives. Good leadership that supports and encourages nursing care that is empathic. Having good role models as nurses that demonstrate empathic care (and physician and other allied health providers. Unsupportive nurse staff and management that are focused on a limited time per patient – the goal is to get them out, and move on"

In summary, eleven nurses responded to the open-ended questions about the circumstances that would aid or hinder their empathic care in the clinical setting which included: 1) Constrained time limits listening and engagement; 2) Challenging patient – nurse interactions impact empathy; 3) A complex, demanding care environment; and 4) Need for a leadership culture that supports empathy.

Summary

Overall, nurse and patient participant's perceptions on nurse empathy were negatively correlated. There were also no significant differences found between their median total scores, including item questions one, four and five about nurse empathy. Significant differences were found on item #2 "asking what is happening in my/patient's life and on item #3 that reflected the

nurse's concern "about the patient and their family". For both items, nurses perceived that they engaged in greater nurse empathy than patients perceived they did during the clinic encounter.

Supplemental analysis included testing the concurrent validity of the SNPOE (five-item self-report) with the JSE-HP (20-item self-report). Correlational analysis revealed there was a strong positive correlation ($r = 0.73$) between the two tools providing evidence on the current validity of the SNPOE with nurses. To the best of this researcher's knowledge, concurrent validity of the SNPOE has not been previously reported.

As guided by Davis's (1994) organizational framework on empathy, this researcher examined patient and characteristics as potential antecedent variables of nurse and patient perceptions of nurse empathy. For patient characteristics, only patient age was a significant factor where: patients who were greater than 70 years of age perceived lower nurse empathy than patients who were between 50 and 70 years of age. For nurse characteristics, nurses who had received advanced training or continuing education in empathy or compassions skills reported significantly higher scores on the SNPOE than nurses who did not have advanced training or continuing education on empathy skills.

Four themes of nurse response to open-ended questions about circumstances that either would encourage or impeded nurses' empathic care in the clinical setting were found, Constrained time limits listening and engagement, Challenging patient – nurse interactions impact empathy, A complex, demanding care environment; and Need for a leadership culture that supports empathy.

Chapter Five - Discussion

This study was designed to compare patient and nurse perceptions of nurse empathy experienced during their encounters in cardiac care out-patient clinics. Overall, this study was guided by Davis's Organizational Model of Empathy [OME] (1994) and Dr. Hojat's (2009) operational definition of empathy. Major findings are interpreted in this chapter and subsequent conclusions are presented. A statement of the study's limitations, nursing practice implications and recommendations for further research are offered.

Nursing is considered both a science and an art, with empathy being considered at the heart of all nursing-patient encounters (Ward et al., 2012). However, this researcher recently conversed with a Gerontological nurse who had 40 years of nursing experience as she read the researchers poster presentation on the importance of empathy in healthcare. After reading the poster, the nurse responded with a chuckle and said "well that is a cute idea". From this comment this researcher could see that empathy is not always embraced by nurses as an essential component that drives human connectedness between a health care provider and the patient. However, literature describes empathy as essential in the clinical setting as a process that promotes the health and well-being of patients – that is, when patients detect that their care provider's embrace a patient-centered stance when inferring their needs (Ward et al., 2012). After an extensive review of empathy literature that dates over the past thirty years, this researcher found little empirical work that compared nurse and patient perceptions of nurse empathy. To address this gap, this researcher endeavored to describe how patients and nurses in ambulatory cardiac care outpatient clinics compare in their perceptions of nurse empathy during clinical outpatient encounters.

Discussion of the Findings

First, this researcher will discuss the representativeness of the current study's sample of cardiac care nurses and patients recruited from cardiac clinics at one tertiary care setting in an urban hospital. Nurse characteristics included basic demographic and level of experience in nursing such as: gender, age, amount of experience in the specialized field, overall nursing experience, and the nurse's current designation (i.e.: nurse - RN, nurse III – clinical /resource nurse specialist, nurse IV – nurse educator, nurse V – Nurse Practitioner [NP], and the nurse's educational designation. In 2010, the average age of nurses who worked in ambulatory care clinics in Canada was 45.4 years of age, 54% worked full time and 28% worked part-time, and 94% were female (CNA, 2012). In addition, 58% of registered nurses working in ambulatory clinics had a RN diploma, 39% had a baccalaureate degree, and 3.3% had a Master's degree (i.e., they worked either as an Advanced Practice Nurse or Nurse Practitioner) (CNA, 2012). On the other hand, the average age of nurse participants in the current study were older than the average age of nurses working in Canada in ambulatory care, and 75% were diploma graduates. Although the characteristics of the nurses in this study resembled the characteristics of nurses who worked in ambulatory clinics across Canada, a generalization regarding these characteristics cannot be made due to the small sample size.

Patient characteristics included basic demographic information related to age, gender, marital status, and length of time spent in the reception area before being seen by a nurse, and their perception of receiving the treatment expected. In Canada, the average age of a patient diagnosed with cardiac disease was 55 years of age, with males being twice as likely as females to be diagnosed with cardiac disease (Government of Canada, 2012). In the current study, there were twice as many male participants then female participants, and the majority of the patient

participants were over 50 years of age. These cardiac patient characteristics are similar to those reported in the literature. Single or divorced adults are more likely to have a heart attack and experience subsequent heart disease; however, the data did not include adults who are in unhappy or unstable marriages (Lewis, 2013). In the current study, 61.2 % of patients reported being married or living together. However, this researcher did not ask further questions related to marital status, therefore it was difficult to compare marital characteristics of this study's sample of patients to those captured in related study samples.

This researcher's main objective was to examine whether there were significant differences found between nurse and patient perceptions of nurse empathy. Nurse participants' response patterns to two brief open-ended pen-and paper questions will be discussed in relation to interpreting their quantitative responses on the nurse empathy tool.

This researcher found no significant correlations or differences on total item scores between nurses self-reports and patient perceptions of nurse empathy. The median total score on the SNPOE (nurse self-report) was 29.5, and on the JSPPNE (patient perception) was 29, suggesting that the nurses thought that they engaged in more empathy in comparison to patient' reports of nurse empathy. This finding is corroborated by the mean score noted for the SNPOE (nurse self-report) of 29.8 that was compared to the mean score of the JSPPNE (patient-perception) of 25.1. A comparison of nurse and patient nurse empathy scores were not found in other studies. Grossman et al. (2014) did not report on overall median or mean scores from their study that used both the JSPPNE and the SRPOE tools.

Significant differences between responses of patients and nurses on individual nurse empathy tool items were found. Nurse responses on "asking what is happening in the patient's life" (SNPOE item two) and "concern about the patients and their family" (SNPOE item three)

were statistically higher than the patient's reports. While nurses felt that they demonstrated the behaviour identified in the two questions, patients provided lower ratings on the same items. This is an interesting, but not unpredicted finding. Although nurses consistently stated that they experienced many barriers to providing empathic care in their open-ended questionnaires, they still rated their empathic care as high. The positive response by the nurses may be related to the design of the nurse empathy tools (i.e. JSE and SNPOE). These tools posed questions about nurse empathy in relation to how the nurse cognitively wished to portray empathic care rather than capturing the actual empathic behaviour enacted by nurses in clinical encounters.

Patients however, acknowledged that the behaviours represented in the response item questions did not necessarily happen or happened to a lesser degree. Interestingly, even though the patients informally told the researcher that "this [respective behaviour described in the response item] did not happen", they still rated that particular behaviour as a three, four, five or a neutral 'do not agree, or disagree' response suggesting that they were somewhat ambivalent toward answering the question. Other researchers have described the same ambivalence by respondents in relation to the use of Likert-type scales when evaluating a situation that they are not necessarily comfortable evaluating, such as another person's behaviour (e.g., Edwards & Smith, 2014, Hojat et al., 2017).

SNPOE question items one ("viewed/I view things from my/my patient's perspective"), question item four ("understood [my/patients] emotions feelings and concerns") and question item five, ("I am/nurse an understanding nurse") were not significantly different between nurse self-report and patient perceptions of nurse empathy. However, it was noted that the nurses median scores were in the lower scale range (5.0, 5.0 and 6.5 respectively) in comparison to patient median scores (6.0, 6.0, and

7.0 respectively) on the same item questions. This is an interesting finding when comparing the two groups and their perspectives. Nurse responses to item questions one, four and five, on the nurse empathy scale could be interpreted as nurses possibly feeling that they needed more involvement and time to perspective-take and attain a good perceptual understanding of the patient's viewpoint. Nurses frequently reported in their open-ended questions that they felt pressed for time when seeing patients as they were aware that patients were waiting to be seen by them in the clinic. Nurses expressed that if they had more time they could provide more empathic care. The theme *Constrained time limits listening and engagement*, reflected the experience of nurses who reported feeling time constrained, which coincided with the patients' perspective on needing more of the nurse's time (i.e. one patient stated to the researcher that the nurse, "really doesn't have time to talk to me"). In this respect, the nurse and patients agreed that the nurse did not have time to support empathic behaviors.

Guided by the theoretical work of Hojat (2009) and Davis (1994), further discussion is warranted in regard to the deleterious impact of when patients do not perceive nurse empathy during clinic encounters. As found in this study, patients perceived less nurse empathy than did nurses on question items about nurses "asking what is happening in [patients] life" and expressing "concern about the patient and their family". The definition of clinical empathy as a "predominantly *cognitive* (rather than emotional) attribute that involves an *understanding* of (rather than a feeling) experiences, concerns and perspectives of the patient, combined with a capacity to *communicate* this understanding and an intention to help" was offered by Hojat et al. (2017). This definition fits with Davis (1994) OME model and his definition of cognitive and behavioral empathy, with the exception of the antecedents related to situations and personal experience. Davis's (1994) OME and Dr. Hojat's definition helped this researcher to speculate

on the difference between nurse self-report of empathy and the patient perception of nurse empathy. The words *cognitive, understanding,* and *communicate* are purposely italicized in this definition by Hojat (2009). Similarly, Davis's model reflected that the cognitive empathy process of perspective taking has potential to positively impact affective and behavioral outcomes such as other-oriented understanding, supportive communication, and helping behaviour. Even if the nurse cognitively understood the patient's experiences, concerns and perspectives of the patient, but did not communicate this understanding, this presents as a lost opportunity for the patient to engage with the nurse in a meaningful way. The possibility of the nurse enacting empathy-driven helping behaviours and being able to meet patients' needs were also lost (Ward, 2014).

Further discussion is warranted in relation to the reliability of responses on nurse empathy by patient participants in the current study. Findings arising from Grossman's (2014) study results were based on a comparison of residents' and standardized patients' reports on resident's empathy. More specifically, these authors' findings indicated that care needs to be taken when comparing health care professionals' self-reports with 'real' versus 'standardized' patient perceptions of health care professional empathy. The participants in the current study consisted of nurses and 'real' patients in a real clinical encounter. In comparison to 'real' patients in the current study, standardized patients are trained professionally to adopt the roles that they portray. Standardized patients also have knowledge of the empathic approach expected in the clinical setting and therefore have been influenced to observe and rate empathic behaviours in their training. Standardized patients have a predetermined role to rate their perception of empathy received based on their previous training in communication and the empathic process. Grossman et al. (2014) reported that residents argued their empathic scores were lower because

they did not feel that standardized patients were ‘real’ and therefore treated them differently than they would interact with a ‘real’ patient in a ‘real’ clinical encounter.

In the current study, ‘real’ patient participants more than likely did not receive training on what to expect from nurses and empathic care. Based on this researcher’s interaction with patient participants it was evident that patients held divergent or ambivalent expectations of nurses and their empathic care. A few patients were hesitant to share their ‘real’ perceptions of nurse empathy that they encountered during their clinic encounter. For example, one participant recently became a Canadian Citizen. He was ecstatic with universal health care and the care he was receiving. This patient provided a perfect nurse empathy score on the patient empathy scale. Another patient stated that the nurse “did not even tell me her name”. However, this patient appeared hesitant to rate the nurse’s empathic care as low. Yet another patient hesitated over the questions and stated that the scoring was difficult to rate low because “it didn’t help that [the nurse] was good looking”. On the other hand, when a younger patient provided a low nurse empathy score, he queried whether his response would get the nurse “in trouble”.

With extant variation in examining ‘real’ patient responses in a clinical setting and standardized patient responses in a mock setting, it is interesting to compare results arising in Grossman et al.’s (2014) study with those found in the current study. Both studies had similar results where there was a non-significant correlation or a negative correlation found between health care professionals’ self-reports and real or standardized patient perceptions of health care professional empathy. On the other hand, another study found a significant low to moderate correlation between the JSP and JSPPE ($r = 0.48$) using real patients during clinical encounters with their physicians (Glaser, Markham, Adler, McManus & Hojat, 2007). However, there was a low correlation ($r = 0.19$) found between scores in a study that employed standardized patients

who evaluated medical students' empathy related encounters (Berg et al, 2011). Systematic reviews on physician empathy reported that 'real' patients tended to report higher perceptions of physician empathy than did 'standardized patients' (Hojat et al., 2017; Kelm et al., 2014). A caveat is therefore warranted when comparing the results of studies that examined 'real' versus 'standardized' patient perceptions of health care professional empathy along with self-reports of healthcare professionals.

Guided by Davis's (1994) OME model on antecedents of empathy, this researcher examined potential linkages between patient and nurse characteristics with patient and nurse reports of nurse empathy, respectively. Regarding patient characteristics, the patient's age was the only patient characteristic that was significantly linked to patient reports on nurse empathy (JSPPNE). Patients who were between 51 and 70 years of age reported a higher nurse empathy score than patients who were over 70 years of age. Rahmqvist and Bara (2010) found that younger patients tended to have a lower perception of nurse empathy than older patients which is in contrast to results from the current study. While engaged in data collection with patients, the researcher noted the words of one patient who stated, "They [nurses] don't talk to me because I am old". Another patient commented "they [nurses] don't talk to me because I can't hear". Ageist attitudes prevail across the health care system and in society (Hadden, 2012). Older adults represent the fastest growing population in Canada. However, due to current health cuts, there are fewer HCPs available to care for the growing older patient population who are in need of more acute care. In turn, patients' families are increasingly being relied upon by the HCPs as partners in patient care that can cause tensions in the patient and HCP's relationship. This tension can be reflected in nurse attitudes towards their patients and families (Hadden, 2012) which was identified by nurse participants in the current study. Nurses described that their ability to practice

empathic care with older cardiac patients was compromised due to perceived interference by families who were concerned with the care of their older family member.

The final question asked of the patient on the demographic survey was, “Did you receive the treatment you expected today”. All of the patient participants responded affirmatively. However, responses to this question did not identify whether patients had received answers to their questions or concerns that they wanted to discuss in addition to their current medical treatment. For example, one patient stated that he had a question about “why this [need for surgery] happened”. However, he did not raise this question as he felt that the nurse was “too busy to talk to me”. Based on some of the qualitative comments and quantitative response patterns of the patients, it was evident that they were experiencing some degree of empathy towards their nurse. One patient described that the nurse was “very paperworky”, while others appreciated that their nurse needed to focus on using the computer, (i.e., to ‘get information”) and getting their tasks done (i.e., “just checks my heart”). Therefore, patients received the treatment that they had come to expect from their nurse, but not the treatment they may have hoped for during the clinical encounter.

With regard to nurse characteristics, advanced training in empathic and/or compassionate care was the only variable that was significantly linked to nurse self-reports on nurse empathy. Nurses with advanced training in empathy reported higher nurse empathy scores than nurses who did not receive advanced training in empathic care. Due to this study’s small sample size, this researcher did not examine whether nurse empathy scores differed from patient perceptions that was dependent on whether or not nurses received advance training in empathy. Ward et al. (2012) reported that student nurse empathy scores increased after receiving advanced training in empathy. It is plausible that this study’s sample of student nurses who received advanced

training reported higher empathy scores because they were more aware of and motivated to practice empathy-related skills. Clearly, researchers need to engage in future experimental studies that examine the impact of empathy training on nurse self-reports and patient perceptions of nurse empathy.

Apart from the positive impact of some nurses having received advanced training in empathic care, this researcher did not find any other nurse characteristics to be linked to nurse self-reports on nurse empathy. It is noted that data on the age of the nurse, the length of nursing experience, and the level of education exhibited limiter variation in nurse responses. It is important to also note that not all classifications and educational levels of nurses were adequately represented in the current study (e.g., there were no Level V nurses or nurse practitioners available in the recruitment setting who volunteered to participate). This suggests an inadequate representation of all nurses who worked in this study's ambulatory cardiac care setting. It is difficult to speculate on whether nurse education and nurse classification levels were possible antecedents to their empathic care.

However, several influential factors were gleaned from nurses' open-ended responses to survey questions on circumstances that impacted empathic care in their workplace. Four themes of nurse responses indicated that nurse empathy was negatively impacted by, *constraints on time which limits listening and engagement, challenging patient-nurse interaction, a complex, demanding work environment* and the *need for leadership culture that supports nurse empathy including positive nurse role models*, which will be discussed further in the following paragraphs.

Qualitative themes derived from nurses' responses to open-ended questions about circumstances that impacted their empathic care appear to be consistent with other study

findings. The first theme, *constrained time limits listening and engagement,* addressed various issues related to time factors nurses in clinic encountered with patients and families. Wiseman (2007) identified time as the greatest and most consistent barrier to an empathic approach taken by nurses. As discussed earlier, nurse participants referred to time as an influential factor that impacted their ability to provide empathic care. Grossman et al. (2014) speculated whether low resident empathy scores occurred due to residents being afforded only brief clinical experiences and limited time to engage in empathic care with their patients. Morse et al. (1992) offered a similar, yet provocative viewpoint when they stated that empathy had no place in the nurse and patient relationship due to time constraints in the workplace. However, it has been demonstrated that basic empathic care can be established in less than 90 seconds (Bayne et al., 2013) by a simple touch, a nod of understanding, active listening, and sitting at the patient's level, and not looking at the computer screen when speaking to the patient. Throughout the literature, authors described that establishing trust and connection by identifying what has meaning for the patient can impact their health and lead to better treatment outcomes plus greater job satisfaction for the HCP (Bayne et al., 2013; Hojat, 2009; Grossman, 2014; Ward, 2012).

A second prominent theme, *Challenging patient – nurse interactions impact empathy,* was related to patient characteristics and behaviors. As guided by Davis's (1994) OME model, some nurses' qualitative responses toward patient characteristics appeared to reflect their engagement in the simple cognitive domain of 'judgement' rather than the higher cognitive domain of "perspective-taking". For instance, nurse comments about the patient's ability to hear, language barriers and families that talk over patients suggested that nurse empathy might have been compromised in the clinical encounter (Bayne, 2012). However, it is these patients and families who can benefit greatly from conscientious empathic care by nurses as they may have

more difficulty understanding their treatment options. Nurse participants also stated that patients who “don’t engage in conversation”, have “high acuity/needs” or are “angry” also presented barriers to empathic care. Bayne (2013) reported similar barriers of physician empathy. As found in the current study, the age difference between older patients and younger nurses may require more conscious effort by nurses to be empathic toward older patients. If nurses were provided with techniques to use their imagination to ‘step inside the patient’s shoes’ and to avoid judgmental attitudes toward patients with certain characteristics (e.g., being older), nurses’ sensitive understanding of patients’ unique needs can be optimized (Lobchuk et al., 2008). Bayne (2013) reported that it is often easier for nurses to connect with patients who have characteristics that are similar to nurses. This is problematic in the provision of patient-centered care where each patient’s unique characteristics, backgrounds and preferences for care need to be respected.

The third theme, *A complex, demanding care environment* and fourth theme, *Need for a leadership culture that supports empathy* addressed factors that also compromised nurse empathy. Nurse participants reported that the busy, time oriented clinic environment was a barrier to empathic care. The nurse participants stressed the need for privacy in meeting with patients and their families in order to develop a trusting relationship. They also described the increased pressure to perform the necessary tasks for each patient, while recognizing that other patients were in the waiting room. Nurse participants also reported that they needed more support from their nurse leaders and managers. Leadership styles that prioritize tasks have been correlated with lower nurse job satisfaction and an unhealthy work environment (Cummings, 2009). Nurse-led clinics would do well to embrace the philosophy of empathy in the clinical setting. To ignore the use of empathy while focusing on the task or pre-planned treatment during the ambulatory clinic visit, as stated in the nurses’ open-ended questionnaires, could potentially

cause patient harm as the treatment does not necessarily fit with the patient's needs (Bayne et al., 2013).

Nurse participants also reported that stronger leadership and better nurse role models who foster the expectation of empathy in the clinic setting were needed. These findings are consistent with studies that have reported on the importance of nurse role models and mentors such as advanced practice nurses (e.g. nurse practitioners and senior management) (Ward et al. 2012). There was a range of classifications of nurses who worked in the current study's recruitment site (i.e. Levels II to V). While nurses who were in higher position classifications and advanced educational experience were potentially more experienced or skilled in the provision of relational skills with patients, it is unfortunate that this classification of nurses did not participate in the current study. Moreover, it might have been interesting to compare the type of role modeling (on empathic relations) provided by nurses in advanced classifications to nurses in other classifications. This researcher can only speculate that nurses who worked in the classifications (e.g., Level II to IV) felt that they needed more workplace supports (i.e., role models and time) to provide empathic care to patients. Bayne et al. (2013) described that these types of supports are particularly significant in care settings where there is a high volume of patients who are scheduled to be seen by HCPs in a short clinical time period.

Empathic care is a critical component of successful clinical performance that ought to be rewarded and cultivated. Nursing leaders, including advanced practice nurses and nurse practitioners have the added responsibility of being a role who provides leadership in empathic care of patients and their families (Ward, 2012). Nurse managers and leaders who demonstrate empathy in the workplace potentially increase the vitality of the nurses they work with (Mortier et al., 2015), that was not captured in the current study. Providing training for all nurses (across

classifications) can build relational skills that enhance empathic care and aid in promoting an energetic, thriving nursing environment (Mortier et al., 2015).

Nurses who work in specialized clinics are afforded unique opportunities to engage in the empathic care with longstanding clients and families encountered in the clinical setting. As noted by patients in the current study, nurse participants were “very knowledgeable” and “know what they are doing”. The continuity of care provided by these nurses also provides a ripe condition for empathic care; this was confirmed by participating nurses in the current study. The availability of advanced practice nurses and nurse leaders, who often work in specialized clinics serve as positive role models by their mentoring, creating a positive and respectful work environment, and engaging in empathic practices. Nurse leaders and advanced practice nurses who demonstrate these supportive characteristics can make important contributions toward nurse well-being, preventing nurse burn-out, and improving patient satisfaction and health outcomes.

Wiseman (2007) postulated that nurses today continue to view the use of empathy in practice from a counselling perspective and not as a means to ‘know’ their patient in the provision of patient-centered care. Wiseman (2007) also noted that role models, a workplace philosophy, the environment, and nurses who feel cared for in their work experience are important considerations for facilitating empathy in the clinical setting. Wiseman (2007) identified similar nurse barriers to practicing empathic care, as identified in the current study (e.g., time, inadequate staffing levels, lack of support from nurse leaders and other medical professionals, stress, and unique characteristics of patients) that can impede an empathic approach.

The responses of nurse participants in the current study provided suggestive clues of job strain. Job strain is defined as a physical and psychological hardship that is felt when an

individual has inadequate power to respond to expectations imposed on them in the workplace environment (Mortier et al., 2015). Moreover, findings arising from this research's thematic analyses suggested that job strain likely contributed toward challenges that nurses faced when providing empathic care. Wisman (2012) reported that nurses who possess greater empathic skills are more likely to report greater job satisfaction and experience fewer feelings of burnout. Studies have indicated that providing empathic care not only supports the patient and their families, but also reduces job strain, psychological distress and bolsters the well-being of nurses in specialized areas of care (Gosselin et al., 2015; Mortier et al., 2015). Future studies on the linkage between nurse empathy and job strain are warranted.

Lastly, a discussion on the adequacy of the OME framework (Davis, 1994) in describing relevant antecedents of perceptions of nurse empathy is warranted. This researcher found that the framework assisted her in identifying potential nurse and patient characteristics as factors that can impact on their perspectives on nurse empathy. However, the OME framework did not included or identify environmental factors in the workplace as potential factors that influence the empathic process as described by nurse participants in the current study. Environmental factors have the ability to thwart empathic care in a given setting, therefore positive modifications to the environment or workplace can improve the empathic process (Freedberg, 2007; Posick et al., 2014). Since the OME framework was derived on empirical works dated before 1994, the researcher recommends continued work to update the framework by including recent empirical works that examined the impact of environmental facts (as antecedents) on empathic processes. It was clear in this study's findings that nurses tried to be empathic but environmental or workplace factors had impeded their ability to engage in empathic care in challenging care settings.

Nursing Implications

This study adds to the literature on empathy in health care from a nursing perspective. Although there is a growing attempt to provide rigorous evidence on empathy in healthcare settings, the results of studies remain inconsistent. This varying evidence is related to the lack of a universal operational definition or theoretical model on empathy for nursing, varied assumptions as to whether empathy can be taught, the reliability of self-report on empathy, and whether standardized patients or real patients provide more reliable reports on health care provider empathy. More importantly, differential opinions by empathy authors and practicing nurses continue to exist as to whether empathy is necessary in the provision of optimal patient care.

With emergent changes in the role of nurses, the increasing number of nurse-led clinics, an aging population, and higher acuity of patients, nurse leaders and clinical managers need to pay greater attention to fostering an empathic workplace where patients and their families feel supported. Managers, nurse leaders, and nurses in advanced practice roles need to be cognizant and supportive of direct patient care nurses who voice their need for training and role models in empathic care. Training strategies for the development of advanced communication skills in nurses ought to occur in conjunction with changes to the environment that includes nurse leaders who learn how to role model relational skills. In empathy training sessions, educators need to be aware of inconsistent evidence on the reliability of ‘real’ versus ‘standardized’ patient reports on nurse empathy. The current study’s findings also suggested that nurses and patients view their empathic encounters from their own perspectives (i.e., as suggested by their differential responses on some empathy scale items). In other words, empathic encounters in clinical settings need to be comprehended from the perspectives of both patients and nurses, and as influenced by

their unique characteristics, beliefs, preferences, and understanding of one another. Providing nurses and parties with opportunities to clarify their perspectives on their empathic engagement in clinic encounters would be beneficial.

Limitations

The study of nurse empathy in real clinical setting presented this researcher with several methodological limitations. The first limitation was related to the non-probability or convenience sample of the nurses and patients who participated in the current study. Patients' unique experiences in the clinic setting might have fostered their positive attitude toward participating in the study (e.g., they experienced a shorter wait time to visit with their health care providers, or they had received positive outcomes from their clinic visit). Nurses who volunteered to participate may be more motivated to engage in empathic behaviours than nurses who did not participate in the current study.

The second limitation was related to the current study's small sample of participating nurses. All eligible nurses were invited to participate in this study (n = 25): only 12 nurses agreed to participate. Despite this researcher's attempts to bolster nurse recruitment (e.g., by providing all nurses with her contact information so they could pose any questions or concerns they might have about the study), no nurses contacted this researcher. Overall, the accrual aim of nurse participants was not achieved to conduct rigorous analyses to answer the posed research questions. Findings arising from this study should be considered as preliminary.

On the other hand, this researcher successfully recruited 43 patient participant responses. A main factor that likely contributed toward patient accrual in this study was the presence of the researcher in the clinic setting. This research was vigilant in reminding registration clerks to approach as many eligible patients as possible to participate in the study.

A third limitation was related to a potential change in nurses' empathic interactions with the patients. Nurse participants were aware that their patients may have volunteered to participate in this study where they were asked to evaluate their nurse's empathy experienced during the clinic encounter. Nurses were informed by the nurse manager that the researcher would be in the clinic surveying patients on their perceptions of patient centered care.

Strengths

The development of this study's research questions was guided by well-known and widely referenced theoretical and conceptual works on empathy by Hojat (2007) and Davis (1994). Their respective bodies of work also assisted this researcher in examining relationships among study variables. Well known, and reliable empathy tools were used to capture nurse and patient perceptions of nurse empathy. Statistical consultation was obtained to ensure that the most rigorous statistical analyses were conducted to answer this study's research questions on patient and nurse responses on nurse empathy. This researcher was sensitive to the challenges in recruiting nurse and patient participants in busy ambulatory cardiac care clinics. Therefore, every attempt was made by this researcher to be transparent or available in the clinic (during recruitment and data collections) to answer any questions or address any concerns of patients and nurses. Although the findings of the current study are considered preliminary, they add to the conversation on clinical empathy and support the need for more rigorous qualitative and quantitative research studies.

Recommendations for Future Research

This study addressed a key gap in the literature on empathic care by nurses working in specialized clinics. Nurses who work in specialized care (e.g. cardiac care) need to be skilled in fostering greater patient engagement and trust, while paying sensitive attention to the emotional

well-being of patients, and their families. More rigorous quantitative and qualitative studies are required to capture the reciprocal nature of empathic experiences as experienced by and from patients and nurses. In addition, future studies need to focus on nurse empathy as perceived by an older patient population, environmental or workplace factors that can effect nurses' empathic processes, and the role of leadership and role models on nurse empathy in the workplace. Although a number of systematic reviews exist in nursing literature on empathy, further integrative work needs to review the theoretical frameworks being used, what consistencies in findings are being reported, what interventions have been tested, and what outcome measures are being used in studies of nurse empathy in specialized areas of care. Studies that examine advanced training in empathic communication and its effect on staff, patient, and family outcomes also need to be conducted.

Of interest for ongoing empirical work and measurement of nurse empathy, this research examined the concurrent validity of the 5-item SNPOE nurse empathy tool. Study findings revealed a moderate to strong correlation between the nurses' self-report on empathy using the JSE-HP 20-item questionnaire and the SNPOE 5-item questionnaire which provided supportive evidence of on the concurrent validity of the SNPOE tool. These results are not unexpected and are consistent with the findings of Grossman et al. (2014) who first used the adapted Survey of Residence Perception of Own Empathy (SRPOE) and the JSE (student version) questionnaires in a study comparing Resident Perception of Own Empathy and standardized patient perception of resident empathy (JSSPPRE). Grossman et al. (2014) reported moderate to strong correlations between the SNROE and the JSE tools.

Summary

As guided by the theoretical work of Hojat (2009) and Davis (1994) on empathic processes and clinical empathy, this chapter presented a discussion of study findings arising from the responses of cardiac care nurses working in ambulatory care and patients dealing with cardiac disease. No significant differences or correlations between total scores by nurses and patients on nurse empathy were found. However, significant differences were found where nurses reported greater nurse empathy than did patients on two empathy scale items, “what is happening in (the patients/my) life” and the nurse “was concerned about (me/the patient) and their family”.

Advanced training by nurses in empathy was positively related to self-reports on nurse empathy. Patients’ reports on nurse empathy suggested that nurse empathy skills were challenged in contexts where patients were older in age. Nurses’ open-ended responses indicated that they faced a plethora of barriers in providing empathic care as captured in the following themes: constrained time limits listening and engagement, challenging patient-nurse interactions impact empathy, a complex, demanding care environment; and the need for a leadership culture that supports empathy.

Finally, this researcher recommends that greater attention needs to focus on developing an operational definition and a theoretical framework for ‘empathy in nurse practice’ that reflects a dual process or reciprocal influence of nurse and patient empathic responses toward each other including antecedents that intrinsically and extrinsically influence their response in clinic encounters.

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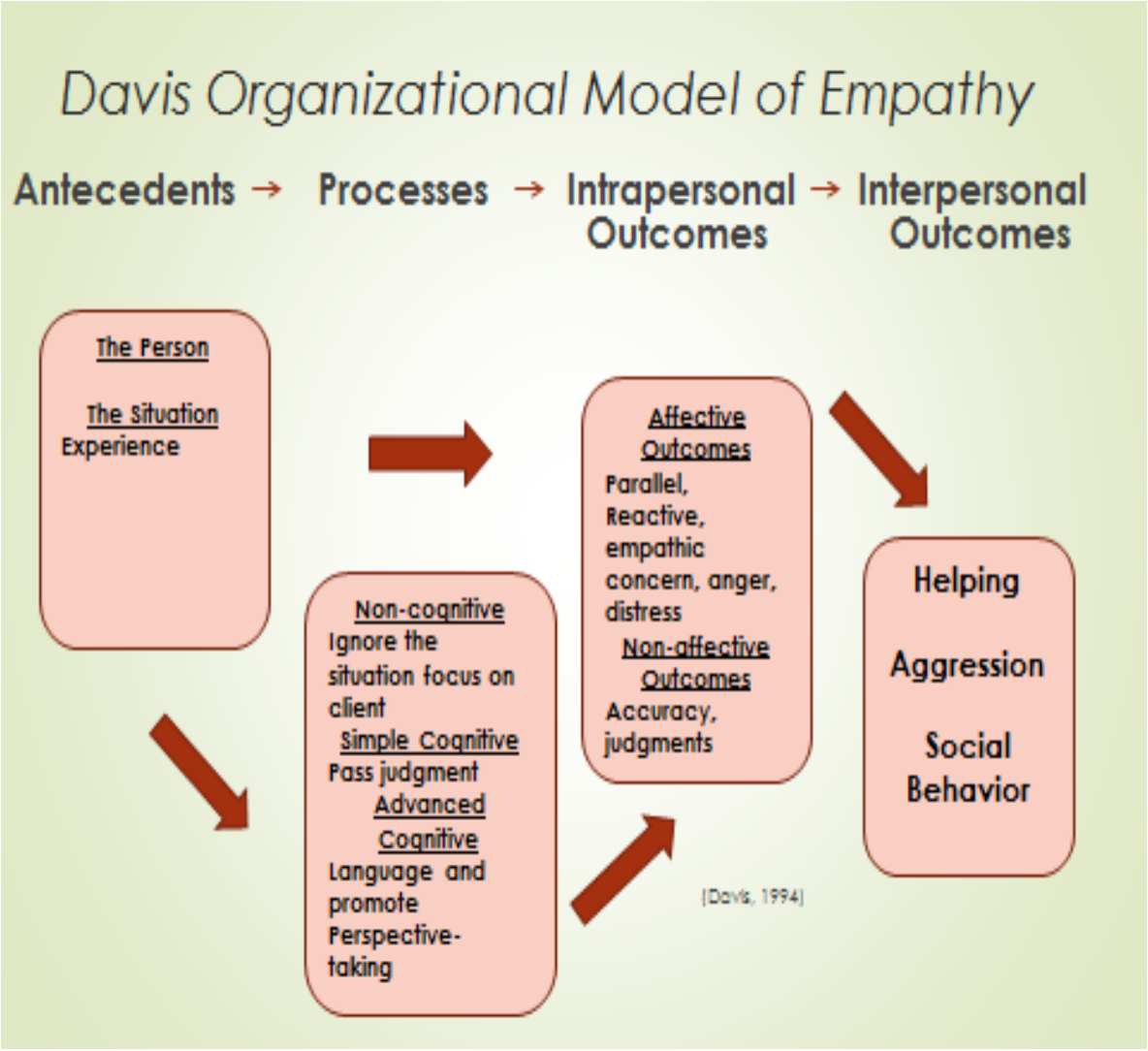
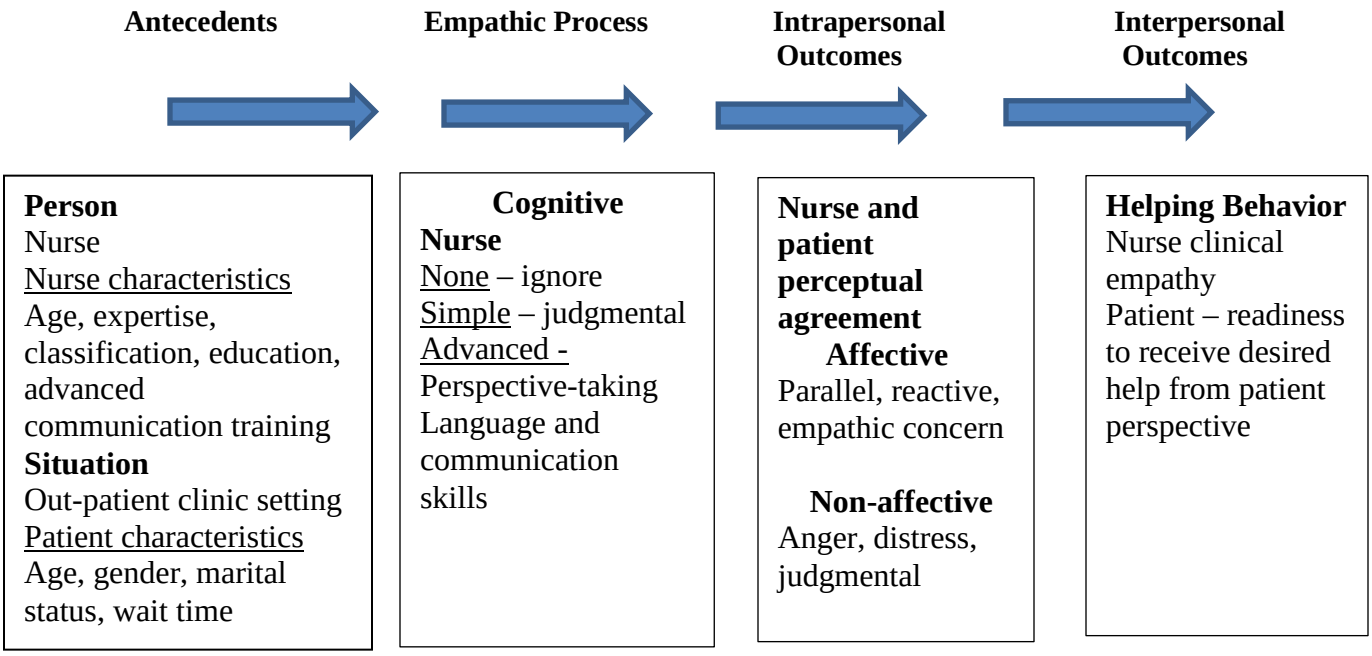
Appendix A

Davis Organizational Model of Empathy



Appendix B

Adapted from Davis (1994) Organizational Model on Empathy (OME)



Appendix C

Inclusion Criteria for Patients

Patients must be:

(1) 18 years of age and over

(2) Fluent in understanding, reading, and writing the English language

(3) Cognitively competent to give informed consent

(4) Able to respond to empathy-related questions about a clinical encounter they had with a nurse while in the cardiac care clinic that day.

Appendix D

Invitation to Patients involved in the Cardiac Sciences Outpatient Clinics

(A study by Tammy Moran RN, BN, Master of Nursing, College of Nursing, University of Manitoba)

Hello,

My name is Tammy Moran. I am a registered nurse and a Graduate Studies student at the College of Nursing, University of Manitoba, Winnipeg. I am doing this research as a final requirement of my Master of Nursing degree. The research is being conducted at an urban hospital and relates to nurse empathy in health care. I am interested in describing and exploring the relationship between nurse and patient perceptions of how nurses engage in empathic responses in the clinic setting. It is hoped that this research will help health care professionals including nurses to better understand how they engage with their patients and guide them in their provision of optimal patient-centered care.

You are invited to participate because you are a patient at the Cardiac Sciences Outpatient Clinics. The information that you provide will be kept strictly confidential. Your participation in the study is voluntary and will not affect the care you currently receive in these clinics or in the future.

If you agree to participate in the research study, it is my intention to provide you with a consent form, a demographic survey and one five question empathy questionnaire. These forms will take approximately five minutes of your time to complete. I will provide you with these forms that you can complete and return to me before you leave the clinic today. If you are interested in participating in this study, please indicate your willingness to speak with me by approaching me at my designated area in the clinic setting. I will then meet with you to explain the research

project in more depth. If you are willing to proceed, I will provide you with the consent form and study questionnaires to complete. As this is a strictly voluntary request, you may choose to not participate.

I thank you in advance for your time thus far.

Tammy Moran RN, BN, Masters of Nursing Graduate Student

Appendix E

University of Manitoba
Rady Faculty of Health Sciences

Invitation to Nurses involved in the Cardiac Sciences Outpatient Clinics

A study by Tammy Moran RN, BN, Master of Nursing, College of Nursing, University of Manitoba

Hello,

My name is Tammy Moran. I am a registered nurse and a Graduate Studies student at the College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg. I am doing thesis research at the urban hospital about empathy in health care. I am interested in describing and exploring the relationship between nurse and patient perceptions of the empathic responses in the clinic setting. It is hoped that this research will provide evidence informed data that will guide the provision of optimal patient-centered care.

You are invited to participate because you are a nurse employed in the Cardiac Sciences Outpatient Clinics. The information that you provide will be kept strictly confidential. Your participation in the study is voluntary and will not affect your employment in the clinics.

If you agree to participate in the research study, it is my intention to provide you with a consent form, a demographic survey and two empathic questionnaires and two questions. These forms will take approximately ten minutes of your time to complete. I will provide a sealed envelope for you to return your completed forms to me. As this is a strictly voluntary request, you may choose to not participate in this study without penalty.

If you have any questions or concerns that you would like to discuss with me, prior to your participation, you may contact me, Tammy Moran E-mail: ummorant@myummanitoba.ca

You may also obtain information and clarification from Tammy Moran's thesis advisor, Dr. Michelle Lobchuk. Michelle Lobchuk 2-4-474-7135 or E-mail: mlobchuk@ummanitoba.ca

I thank you in advance for your time.

Tammy Moran RN, BN, Masters of Nursing Graduate Student

Appendix F

Informed Consent Form – Cardiac Sciences Out-Patient Clinic Nurses

Research Project Title: A Comparative Study of Nurses' Self-Report of Empathy with Patients' Perceptions of Nurse Empathy in Cardiac Outpatient Clinics in an Urban Hospital.

Researcher: Tammy Moran, Graduate Student, College of Nursing, University of Manitoba.

Thesis Advisory Committee: Dr. Michelle Lobchuk (chair), University of Manitoba, College of Nursing; Dr. Christina West, University of Manitoba, College of Nursing; Dr. Debra Gural, University of Winnipeg and Dr. M. Hojat, Thomas Jefferson University in Philadelphia, Pennsylvania

Sponsor: This is a non-funded study.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand the accompanying information.

What is the nature and purpose of the study?

You are invited to take part in a study regarding nurse empathy in healthcare. The purpose of this study is to describe how patients and nurses in cardiac care out-patient clinics, compare in their perceptions of nurse empathy during clinic encounters.

What am I being asked to consent to? What is the nature of my participation in the study?

Firstly, you are being asked to participate in this study that involves your completion of two surveys that are attached to this consent form. If you consent to take part in the study this means that you agree to complete three one-time only surveys (demographic and two empathy questionnaires) and one form that includes two question, presented to you. All eligible nurses in the Cardiac Sciences Out-Patient Clinics will be invited to participate in this study. I expect that it will take you about ten minutes in total, to complete the demographic data form, the two nurse empathy questionnaires and the two questions. The demographic data form asks questions concerning personal characteristics about your age, gender, years of experience in a specialized field, years of experience as a nurse and level of education. The second questionnaire contains twenty questions and the third questionnaire contains five questions. Each of these questionnaires asks you to describe the empathic approach you take with patients in the clinic. A fourth questionnaire has two questions that ask you to answer in your own words your thoughts concerning empathy.

If you feel you understand your role in the study and agree to participate, please sign and return this informed consent form plus the attached questionnaires in the enclosed envelope and place it in the sealed box provided. If you do not wish to participate in the study you will not be enrolled. Once you have completed the three questionnaires and the two questions, no more of your time will be required.

How will the information be handled during and after the study?

Your privacy is important. Therefore, your participation is anonymous, and your responses on the surveys will be kept confidential. No personal identifying information will be recorded on any of the data collection forms for this study. Any information you provide to the researcher will be kept confidential.

Survey. Your identity will be protected by assigning you a code number that is known only to the researcher, Tammy Moran. Only Tammy will know if you participated or not in the study. Tammy Moran, the thesis committee (Dr. M. Lobchuk, Dr. C. West, Dr. D. Gural, and Dr. M. Hojat), and Dr. Rasheda Rabbaini, (biostatistician) will have access to your completed questionnaires, which will identify only your assigned code number. During and after the study all materials will be kept in a locked file cabinet at the home office of Tammy Moran (the researcher). All data exported to software will be kept on a secure computer that will be password protected and known only by Tammy. Study data will be kept for seven years and will be destroyed as confidential waste (shredded) and deleted from Tammy's computer and hard drive. If the study results are published, under no circumstance will identifying information appear anywhere in the publication. The identity of the hospital and clinic sites will not be revealed.

What are the benefits and burdens of participating?

There are no known burdens in participating in this study. The study will not benefit you directly. The research findings may have a benefit to future decision making about empathic support by nurses in ambulatory care clinics and future research studies.

Can I get a copy of the results of the study?

A summary of the results of the study will be made available to you if you would like to receive them. If you wish to receive this summary, please fill out the form at the end of the consent.

Cost and Compensation

There is no cost for you to participate in this research study. No compensation will be given to participants.

Contact Persons

If you have any questions about this research study, please call Tammy Moran, study researcher. You may also obtain information and clarification from Tammy Moran's thesis advisor, Dr. Michelle Lobchuk.

Telephone numbers:

Tammy Moran @ E-mail: ummorant@myummanitoba.ca

Michelle Lobchuk 204-474-7135 or E-mail: mlobchuk@ummanitoba.ca

This study has been approved by:

This research has been approved by the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba and Access approval has been obtained from the urban hospital. If you have any concerns or complaints about this project, you may contact the Human Ethics Secretariat at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participating in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudices or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. You can stop at any time and you are free to withdraw from the study at any time and within two weeks of completing the questionnaires. If you wish to withdraw from the study within two weeks of completing the questionnaires, please call Tammy Moran at 204-803-7498 and inform her of your decision so that your data will not be used and will be destroyed.

Please keep a copy of this form for your records.

The University of Manitoba and the urban hospital may look at the research-related records to see that the research is being done in a safe and proper way.

If you consent to volunteer for this research study, please sign below:

_____	_____	_____
Participants Name (please print)	Participants Signature	Date
_____	_____	_____
Researchers Name (please print)	Researchers Signature	Date

If you would like to receive a summary of the results of this study, please fill out the form below:

Name of person to whom the study results should be sent to:

_____

Mailing address:

_____

_____

Postal Code:

_____

Appendix G

Nurse – Demographic Survey

The following survey is presented to you by the researcher in an effort to garner information about participant's characteristics that may influence the survey results. All of your responses will remain confidential and are completely voluntary. Please do not write your name on this questionnaire. Instead you are provided with a code number.

---

1. **Which gender do you identify with?**

   _____female

   _____male

   _____I prefer not to answer

2. **What is your age (years)?**

   _____ 20-30 years

   _____ 31-40 years

   _____ 41-50 years

   _____ 51-60 years

   _____ >60 years

   _____ I prefer not to answer

3. **Number of years as a nurse**

   _____ 0 to < 1 year

_____>1 to <6 years

_____ >6 to <10 years

_____>10 to < 15 years

_____15 to < 20 years

_____>20 to < 35 years

_____> 35 years

_____I prefer not to answer

4. **Number of years as a cardiac nurse**

   _____years

   _____ I prefer not to answer

5. **What level of nursing do you currently work in?**

   _____Nurse II _____Nurse III _____Nurse IV _____Nurse V

6. **Highest level of completed education**

   _____Hospital Diploma

   _____ College Diploma in Nursing

   _____ Bachelor Degree in Nursing

   _____ Bachelor Degree in Different Field

   _____Master Degree in Nursing

   _____ Nurse Practitioner

   _____Master Degree in Different Field

   _____PhD in Nursing

_____PhD in Different Field

7. **What is your employment status in the cardiac clinic?**

   _____Full-time

   _____Part- time

   _____Casual

8. **Have you received advanced training or continuing education in:**

   (a) Communication skills? ____yes ____no

   (b) Empathy or compassion skills? _____yes ____ no

   (c) Patient-centered care? ____ yes ____ no

Appendix H

Jefferson Scale of Empathy – Health Professional

Instructions: Using a ball-point pen, please indicate the extent of your agreement or disagreement with *each* of the following statements by marking the appropriate circle to the right of each statement.

Please use the following 7-point scale (*a higher number on the scale indicates more agreement):*

Mark one and only one response for each statement.

1-------2-------3-------4-------5-------6-------7

Strongly Disagree Strongly Agree

1. My understanding of how my patients and their families feel does not influence medical or surgical treatment.....

1 2 3 4 5 6 7

2. My patients feel better when I understand their feelings. .....

3. It is difficult for me to view things from my patients' perspectives.....

4. I consider understanding my patients' body language as important as verbal communication in caregiver-patient relationships.....

5. I have a good sense of humor that I think contributes to a better clinical outcome. .....

6. Because people are different, it is difficult for me to see things from my patients' perspectives.....

7. I try not to pay attention to my patients' emotions in history taking or in asking about their physical health.....

8. Attentiveness to my patients' personal experiences does not influence treatment outcomes. .....

9. I try to imagine myself in my patients' shoes when providing care to them. .....

10. My patients value my understanding of their feelings which is therapeutic in its own

right.....

11. Patients' illnesses can be cured only by medical or surgical treatment; therefore, emotional ties to my patients do not have a significant influence on medical or surgical outcomes. .....

12. Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints. .....

13. I try to understand what is going on in my patients' minds by paying attention to their non-verbal cues and body language.....

14. I believe that emotion has no place in the treatment of medical illness. .....

15. Empathy is a therapeutic skill without which success in treatment is limited. .....

16. An important component of the relationship with my patients is my understanding of their emotional status, as well as that of their families.....

17. I try to think like my patients in order to render better care. .....

18. I do not allow myself to be influenced by strong personal bonds between my patients and their family members. .....

19. I do not enjoy reading non-medical literature or the arts.....

20. I believe that empathy is an important therapeutic factor in medical or surgical treatment. .....

Appendix I

Scale of Nurse Perception of Own Empathy [SNPOE]

Instructions: We would like to know the extent of your agreement or disagreement with each of the following statements below. Please use the following 7-point scale and write your rating number from 1 to 7 on the underlined space before each statement (1 means you Strongly Disagree, and 7 means you Strongly Agree with the statement, a higher number indicates more agreement).

1-------2-------3-------4-------5-------6-------7

Strongly Disagree Strongly Agree

---

1. **_____ I viewed things from my patient's perspective (sees things as he/she sees them).**
2. **_____ I asked about what is happening in my patient's life.**
3. **_____ I am concerned about the patient and their family.**
4. **_____ I understood the emotions, feelings and concerns of my patients.**
5. **_____ I am an understanding nurse.**

Appendix J

Nurse Questionnaire

Please answer these questions.

1. **What circumstances make it easier for you to engage in empathic care with your patients in the outpatient cardiac clinic?**

_____

_____

_____

_____

_____

_____

2. **What circumstances make it harder for you to engage in empathic care with patients in the outpatient cardiac clinic?**

_____

_____

_____

_____

_____

_____

Appendix K

University of Manitoba
Rady Faculty of Health Sciences

Informed Consent Form – Cardiac Sciences Outpatient Clinic Patients

Research Project Title: A Comparative Study of Nurses' Self-Report of Empathy with Patients' Perceptions of Nurse Empathy in Cardiac Outpatient Clinics in an Urban Hospital.

Researcher: Tammy Moran, Graduate Student, College of Nursing, University of Manitoba.

Thesis Advisory Committee: Dr. Michelle Lobchuk (chair), University of Manitoba, College of Nursing; Dr. Christina West, University of Manitoba, College of Nursing; Dr. Debra Gural, University of Winnipeg and Dr. M. Hojat, Thomas Jefferson University, Philadelphia, Pennsylvania

Sponsor: This is a non-funded study.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, do not hesitate to ask. Please take the time to read this carefully and to understand the accompanying information.

What is the nature and purpose of the study?

You are invited to take part in a study regarding nurse empathy in healthcare. The purpose of this study is to describe how patients and nurses in cardiac care out-patient clinics compare in their perceptions of nurse empathy during clinical encounters.

What am I being asked to consent to? What is the nature of my participation in the study?

First, you are being asked to participate in this study that involves your completion of two surveys that are attached to this consent form. If you consent to take part in the study this means

that you agree to complete two one-time only questionnaires (demographic and empathy questionnaire) presented to you. All eligible patients, during the researcher's (Tammy Moran) visit day at the Cardiac Sciences Out-Patient Clinics, at the urban hospital, will be invited to participate in this study. It is expected that it will take you about five minutes to complete the demographic data form and the Jefferson Scale of Patient's Perception of Nurse Empathy. The demographic data form and the nurse empathy questionnaire. The demographic data form asks questions concerning your personal characteristics such as: age, gender, name of clinic attended, amount of wait time spent in the clinic reception area, and if expected treatment was received. The second questionnaire contains five questions that ask you to describe the nurse's empathic approach toward you during your clinic visit today.

If you feel you understand your role in the study and agree to participate, please sign and return this informed consent form plus the attached questionnaires to the researcher (Tammy) in the attached envelope before you leave the clinic today. If you do not wish to participate in the study you will not be enrolled. Once you have completed the two questionnaires no more of your time will be required.

How will the information be handled during and after the study?

Your privacy is important. Therefore, your participation is anonymous, and your responses on the surveys will be kept confidential. No personal identifying information will be recorded on any of the data collection forms or transcripts in this study. Any information you provide to the researcher will be kept confidential.

Your identity will be protected by assigning you a code number that is known only to Tammy Moran. Only Tammy will know if you participated or not in the study.

Tammy, the thesis committee members (Dr. M. Lobchuk, Dr. C. West, Dr. D. Gural and Dr. M. Hojat), and Dr. Rashida Rabaini (biostatistician) will have access to the questionnaires that you complete which will only have your code number on it. During and after the study all materials will be kept in a locked drawer at the home office of Tammy Moran (the researcher). All data exported to software will be kept on a secure computer that will be password protected and known only by Tammy. Study data will be kept for seven years and will be destroyed as confidential waste (shredded) and deleted from Tammy's computer and hard drive. If the study results are published, under no circumstance will identifying information appear in any written or published reports. The identity of the hospital and clinic sites will not be revealed.

What are the benefits and burdens of participating?

To the best of the researcher's knowledge, there are no burdens in participating in this study. The study will not benefit you directly. The research findings may have a benefit to future decision making and research studies.

Can I get a copy of the results of the study?

A summary of the results of the study will be made available to you if you would like to receive them. If you wish to receive this summary, please fill out the form at the end of the consent.

Cost and Compensation

There is no cost for you to participate in this research study. No compensation will be given to participants.

Contact Persons

If you have any questions about this research study, please call Tammy Moran, study researcher. You may also obtain information and clarification from Tammy Moran's thesis advisor, Dr. Michelle Lobchuk.

Telephone numbers:

Tammy Moran e-mail: ummorant@myumanitoba.ca

Michelle Lobchuk 204-474-7135 or email: mlobchuk@umanitoba.ca

This study has been approved by:

This research has been approved by the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba and Access approval has been obtained from the urban hospital. If you have any concerns or complaints about this project, you may contact the Human Ethics Secretariat at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participating in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudices or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. Your decision to participate in the survey is voluntary. You can stop at any time and you are free to withdraw from the study at any time. If you wish to withdraw from the study within two weeks of completing the questionnaires, please call Tammy Moran at 204-803-7498

and inform her of your decision so that your data will not be used and will be destroyed. Please keep a copy of this form for your records.

The University of Manitoba and the urban hospital may look at your research-related records to see that the research is being done in a safe and proper way.

If you consent to volunteer for this research study, please sign below:

_____	_____	_____
Participants Name (please print)	Participants Signature	Date
_____	_____	_____
Researchers Name (please print)	Researchers Signature	Date

If you would like to receive a summary of the results of this study, please fill out the form below:

Name of person to whom the study results should be sent to:

_____

Mailing address:

_____

_____

Postal Code:

_____

Appendix L

Patient code #_____

Patient – Demographic Survey

The following survey is presented to you by the researcher in an effort to garner information about participant's characteristics that may influence the survey results. All of your responses will remain confidential and are completely voluntary. Please do not write your name on this questionnaire. Instead you are assigned a code number.

---

1. **What is your age range (years)?**

   _____ 18-30 yrs.

   _____ 31-50 yrs.

   _____ 51-70 yrs.

   _____ >70 + yrs.

   _____ I prefer not to answer

2. **What gender do you identify as?**

   _____ Male

   _____ Female

   _____ I prefer not to answer

3. **What is your marital status?**

   _____ Married

   _____ Common-law

   _____Never Married

   _____Widowed

   _____ Separated

_____ Divorced

_____I prefer not to answer

4. **Which clinic did you attend today?**

(list clinics when known)_____

5. **How long did you wait in the reception area before seeing the health practitioner?**

_____ Minutes

6. **Did you receive the treatment you expected today?**

_____ Yes

_____ No

_____ I prefer not to answer

Appendix M

Jefferson Scale of Patient Perceptions of Nurse Empathy [JSPPNE]

Instructions: We would like to know the extent of your agreement or disagreement with each of the following statements about your nurse that you experienced today in the clinic. Please use the following 7-point scale and write your rating number from 1 to 7 on the underlined space before each statement (1 means you Strongly Disagree, and 7 means you Strongly Agree with the statement, a higher number indicates more agreement).

1-------2-------3-------4-------5-------6-------7

Strongly Disagree Strongly Agree

The nurse that I visited with today in the clinic:

1. **_____ Viewed things from my perspective (sees things as I see them).**
2. **_____ Asked about what is happening in my life.**
3. **_____ Seemed concerned about me and my family.**
4. **_____ Understood my emotions, feelings and concerns.**
5. **_____ Was an understanding nurse.**

Patient code #_____

Appendix N
Research Question # 6

Research Question #6

CODE: "Time" #6. "Time with my patient" **Sub-code "time to hear"** #1: "Time with my patient to hear their personal story and to connect" **Sub-code "situations**" #3: "Take time with patients ……when dealing with difficult situations or potentially explosive ones" **Sub-code "time to listen"** #4: "Having time to listen." #5. "Time, taking the time to listen to what the patient is feeling, perceiving of his/her medical journey." #9. "When I have time to spend with the patients" **Sub-code "time to engage"** #12. "Having time to engage in a conversation as I provide care"	Nurse Statements about having or choosing to take sufficient time and seize opportunities to relate, connect, and listen or hear the patients story or viewpoint during the clinic encounter
CODE: Patient characteristics **Sub-code:** **"Listening skills"** #4: "Their ability to hear." **"Language"** #9. "When there is no language barrier **"Personality skills"** #9. "Patients have open personality"	**Nurse statements about characteristics and skills of patients that aid nurses' ability to engage in empathic care.**
CODE: Staff communication #4: "Having adequate communication amongst staff." **Sub-code - knowledge** #12. "Being open to acknowledge the patients as a whole person, understanding that their medical issue may be effected by other factors in their lives"	**Nurse statements about the interpersonal interaction among staff or health are team members that aid nurses' ability to engage in empathic care**
CODE: Environment #2: "In order to set an environment of calm, trust and care for the patient and	**Nurse statements about the work environment and its effect on their ability to provide empathic care to the patient.**

family, there needs to be enough time allotted to fulfil basic medical information exchange and enough time to allow patients and family to speak to their worries and unique situations." #5: "We are a busy, time orientated clinic should a patient need my time for me it is mine to give not always but if needed so be it." **Sub-code** **"busy"** #6. "On a busy clinic day-it is difficult to get more involved as I am distracted by the number of patients waiting to be seen." #7. "When I am not rushed during a patient assessment." **"data gathering"** #7. "Difficult to engage with a patient when so much data gathering is required." **"continuity"** #9. "When I see the patients more than once or for a longer visit" #10. "Continuity of care. Developing a relationship with the patient establishing trust and confidence." **"privacy"** #12. "Having a private space for history taking" #11. "One on one in the office allows for privacy and open about their feelings and discuss family and personal situations."	

Appendix O

Research Question # 7

Cue Category (Code and sub-code)	Definition
1.Challenging patient behaviour	Nurse statements about challenges in dealing with behaviour of patients that thwart their ability to engage in empathic care
Sub-codes **"C**ombative or argumentative" #1. "If a patient has a combative or argumentative presentation" **"Anger"** #11. '…bad attitude or anger misdirected at me"	
2.Past medical experience	Nurse statements about past medical experience the patient has encountered
Sub-codes **"past experience"** #11. "Bad experience by either themselves or someone they know" **"trust"** #2. "Patient has experienced a breech in trust…"	
3.Patient knowledge and preparation for visit # 5. "…isn't properly prepped for the appointment"	Nurse statements about inadequate preparation of the patient for their visit
4.Family disruptions #6. "Family that talks over the patient and interrupts the patient"	Nurse statements about attending family members who were perceived as being disruptive toward the nurse's ability to engage in empathic care of the patient
5.Patient characteristics	Nurse statements about characteristics and skills of patients that they feel prevent nurses' ability to engage in empathic care
Sub-codes **"Language barrier"** #9. "When there is no language barrier" "**Personality type"** #9 "patients who don't engage in conversation" "**Patient acuity"**	

#4. "High acuity/needs of patients" #5. "These patients' (angry) often have high needs."	
6.Time #3. "…time can be a factor if unforeseen circumstances arise. It becomes difficult to be fair to all patients in the clinic area when some need extra time." #5. "…time given to have themselves heard and understood"	Nurse statements about the time required by nurses to engage in the empathic care of patients as impacted by unexpected circumstances or difficult situations in the clinic setting
7.Environment	Nurse statements about the work environment and its effect on their ability to provide empathic care to the patient
Sub-codes **Direct admit** #3. "There are times when you would like…to direct admit patients in order to avoid an emergency wait time…" **Busy** #4. "Busy clinic. Short staffed" #10. "Time, often there is not enough time to engage patients…" **Short assessment times** #6. "Scheduled short clinic assessment times" **Rushed** **#7. "**When I see several patients in the waiting room that need to be seen makes the 1:1 difficult because you know another patient needs to be seen."	
8. **Leadership** #12. "Unsupportive nurse staff and management that are focused on a limited time per patient-the goal is get them in and out…"	Nurse statements about the nurse and their role in supporting empathic care in the clinical setting.
Sub-code **Short staffed** #12. "Taking extra time with patients is often not encouraged because our department is already short staffed." **Unpaid time**	

#12. If someone is complicated and I take additional tie to support the patient, I often have to stay overtime or miss my lunch break." #12. "Taking extra time with patients is often not encouraged because our department is already short staffed"	

Appendix P
Themes from Question #6 and #7

Themes from Question #6 and #7

Theme	Examples
Time **Definition:** Nurses statements about the time required by nurses to engage in the empathic care of patients as impacted by unexpected circumstances or difficult situations in the clinic setting.	#1: "Time with my patient to hear their personal story and to connect" #4: "Having time to listen." #12. "Having time to engage in a conversation as I provide care" #3. "…time can be a factor if unforeseen circumstances arise. It becomes difficult to be fair to all patients in the clinic area when some need extra time." #5. "…time given to have themselves heard and understood." #3. "…time can be a factor if unforeseen circumstances arise. #12. "Having time to engage in a conversation as I provide care" #3: "Take time with patients ……when dealing with difficult situations or potentially explosive ones" #5: "We are a busy, time orientated clinic should a patient need my time for me it is mine to give not always but if needed so be it."
Challenging patient behaviour/characteristics **Definition:** Nurse statements about challenges encountered when dealing with behaviours of patients that thwart their ability to engage in empathic care.	#4: "Their ability to hear." #9. "When there is no language barrier." #9. "Patients have open personality" #1: "If a patient has a combative or argumentative presentation" #2: "Patients that have experienced a breach in trust (e.g. disrespect, incompetence) with previous medical encounter are more closed down and skeptical towards an understanding, competent encounter" #11. "Patient's bad attitude or anger misdirected at me." #11. "Bad experience by either themselves or someone they know." #6. "Family that talks over the patient and interrupts the patient." #6. "language barrier" #9. "language barrier" #5. "An angry patient can make it more difficult to engage in empathic care." #10. "Past experience with health care professionals" #9. "patients who don't engage in conversation" #4. "High acuity/needs of patients." #5. "These patient's (angry) often have high needs."
Environment in the clinic	#12. "Having a private space for history taking"

Definition: Nurse statements about the work environment and its effect on their ability to provide empathic care to the patient	#11. "One on one in the office allows for privacy and open about their feelings and discuss family and personal situations." #5. "…other circumstances when a patient isn't properly prepped for the appointment slows the appointment down not allowing for time to engage." #6. "Scheduled short clinic assessment times" #7. "When I see several patients in the waiting room that need to be seen makes the 1:1 difficult because you know another patient needs to be seen." #9. "being rushed" #6. "On a busy clinic day-it is difficult to get more involved as I am distracted by the number of patients waiting to be seen." #7. "When I am not rushed during a patient assessment." #7. "Difficult to engage with a patient when so much data gathering is required." #9. "When I see the patients more than once or for a longer visit" #10. "Continuity of care. Developing a relationship with the patient establishing trust and confidence." #2: "In order to set an environment of calm, trust and care for the patient and family, there needs to be enough time allotted to fulfil basic medical information exchange and enough time to allow patients and family to speak to their worries and unique situations." #4:"Busy clinic.
Leadership role **Definition:** Nurse statements about other nurses, nurse managers and health care professionals in support of their empathic care provided in the clinical setting.	#12. "If someone is complicated and I take additional time to support the patient, I often have to stay overtime or miss my lunch break." #12. "Taking extra time with patients is often not encouraged because our department is already short staffed." #4: "Having adequate communication amongst staff." #12. "Being open to acknowledge the patients as a whole person, understanding that their medical issue may be effected by other factors in their lives" #12. "Good leadership that supports and encourages nursing care that is empathic." #12. "Having good role models as nurses that demonstrate empathic care (and physicians and other allied health providers" #4: "Short staffed." # 9. "Time-often there is not enough time to engage patients as clinic is booked and patients are waiting and doctors are pushing to see patients more quickly not allowing for in depth conversations and empathy." #12. "Unsupportive nurse staff and management that are focused on a limited time per patient – the goal is get them in and out … and move on."

	#5. “Are when a patient isn’t properly prepped for the appointment this slows the appointment down not allowing for time to engage.” #3: “There are times when you would like…..to direct admit patients in order to avoid an emergency wait time, but the option is not always available”