A STUDY OF
NURSES' EMPATHY IN TWO DIFFERENT NURSING
CARE DELIVERY SYSTEMS

by

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Empathy has been identified as a critical dimension in helping relationships. The backbone of nursing is the development of meaningful one-on-one relationships with clients. It stands to reason that empathic disposition and ability are important dimensions in nursing practice. Influences on the use of these dimensions in practice are important considerations for nurse researchers. Arguably, the nursing care delivery system being practiced may have an impact on the nurse's attitude towards the use of empathy in relationships with clients. The purpose of this study was to compare the trait empathy levels of nurses working in a functional nursing care delivery system with nurses working in a delivery system using a primary nursing philosophy.

Fifty five respondents from two large teaching hospitals in New Brunswick participated in the study. Trait empathy was measured using LaMonica's Empathy Construct Rating Scale, and values from each nursing care delivery system were also assessed according to their impact on the way the nurses preferred to practice and possible influence on empathic attitudes.

Results showed no significant differences in nurse trait empathy between the two nursing care delivery systems. All respondents scored moderately high on the trait empathy measure, and all respondents showed a preference for the values inherent in the primary nursing care delivery system.

The social context of the nurses' worklife became evident during the course of the study, as some respondents expressed their frustration with the research being carried out, particularly with the length and wording of the trait empathy measure.

The multiple factors influencing nursing today must be taken into consideration when conducting research in the practice environment. Nurses are, more than ever, very concerned about their practice. They are concerned about compromising quality care, and resultant patient outcomes. It is important for nurse researchers to remain aware of the current working world of the nurse in order to support these concerns.
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CHAPTER 1

Introduction

Nursing has long been recognized as a caring profession. In order to convey this care to patients, nurses need specific attitudes and skills. In particular, nurses need to be compassionate and have the ability to sense how another person is feeling in a given situation, that is to be empathic (Burnard, 1988; Carkhuff, 1969; Gazda, Childers, & Walters, 1982; LaMonica, 1985; MacKay, Hughes & Carver, 1990; Rogers, 1957). The effective use of empathy allows nurses to indicate to clients that they have fully heard and interpreted verbal and non-verbal messages.

There are many competing forces within the hospital environment that promote or undermine the nurse’s use of empathy in the development of caring relationships. The increasing use of medical information systems, advances in technology and pharmacology, and the devastating effects of cuts in health care funding all compete for the nurse’s attention, and limit the time and attention required for the development of empathic relationships with clients. In addition, the nursing care delivery system in which nurses practice arguably has an impact on the nurse’s inclination to use empathy in relationships with clients (Horvath, 1990; Leach, 1993). Two philosophically different nursing care delivery systems practiced today are primary nursing and functional nursing. The values of autonomy, responsibility and accountability have been purported as the main tenets of the primary nursing philosophy (Manthey, 1990).
Functional nursing, on the other hand, claims to value efficiency in task accomplishment (Berger & Williams, 1992). The values inherent in the practice of primary nursing which promote a one-on-one relationship between nurse and client may provide more opportunity for empathic interactions than the influence of functional nursing which values task accomplishment.

Because empathy has been identified as a critical dimension in therapeutic relationships and research has shown that the use of empathy has a positive effect on patient outcomes, it is important to consider the influence that a nursing care delivery system may have on nurses' tendency to use empathy in their relationships with clients.

**Literature Review**

**Conceptualizations of Empathy**

The study of empathy in therapeutic relationships is not new. The term has its roots in the early part of this century (Deutsch & Madle, 1975). Lipps, a psychologist, coined the term empathy from the German word *Einfühlung* which described feelings experienced when viewing art or sculpture. It conveyed the idea of generating feeling from inanimate objects (Barrett-Lennard, 1981).

Empathy then took on a broader scope through its use in psychotherapy. Carl Rogers (1957), an eminent psychotherapist practicing in the 1950s and early 1960s, thought of empathy as a prerequisite for effective counselling. He described it as the capacity "to sense the client's world as if it were your own, without ever losing the 'as if' quality" (Rogers, 1957, p.99). Empathy has also
been defined as "a central feeling with and in the client's world. It involves accurate perception of the client's world by the helper, communication of this understanding to the client, and the client's perception of the helper's understanding" (La Monica, 1981, p.398).

Empathy has been distinguished from other closely related terms in nursing literature in relation to focus, relationship, perception, individuality and potential for growth in the client. Forsyth (1980) argues that empathy is not sympathy, a concept that denotes an 'I-it' response, in which the focus is on both the nurse's and patient's feelings and the nurse's feelings often mimic the patient's response. Forsyth also argues that empathy is not pity, a form of deep sympathy which does not require a relationship to exist and tends to devalue the recipient. People who pity feel detached and relieved that they are not experiencing the identified situation. Forsyth further differentiates empathy from compassion, an emotion which is evoked only by the sorrows or misfortunes of another. Compassion conveys the notion that the person feels for another person but does not indicate that there has been a perception about how that person is feeling. Unlike empathy, none of these related concepts indicates any growth potential.

Zderad (1969) and Holden (1990) distinguish empathy from the defense mechanisms of identification, in which one person adopts another's behavior or attitude, and projection, in which a person attributes his/her own attitudes or behavior to another person. These defenses are not the same as empathy
because they lose the distinctiveness of the individuals. In contrast, empathy necessitates that the empathizer maintain a separate identity while still being able to appreciate the position of another individual. Holden (1990) also distinguished empathy from counter-transference, which leads to the helper withdrawing from the relationship or becoming an over-vigilant caregiver, neither of which can contribute to growth in the patient. In contrast, the use of empathy maintains a comfortable space between the helper and helpee and provides a level of insight which encourages self-understanding and growth.

The concept of empathy as a prerequisite for the caring profession of nursing began to evolve from Florence Nightingale's recommendations in Notes on Nursing (1969), when she asked that nurses put themselves imaginatively into the role of their patients in order to understand the effects that the environment and other people have on them (Dunlop, 1986). Nursing has gone through various stages of describing ideal relationships with patients. Early nurses were encouraged to be sympathetic but to remain emotionally detached and not allow their own feelings to interfere with their professionalism. In the 1930s, nurses became more aware of psychological aspects of caring for patients and more emphasis was placed on the use of sympathy as essential to effective nurse-patient relationships (Morse, Anderson, Bottorf, Yonge, O'Brien, Solberg, & McIlveen, 1992).

The term empathy was not adopted by nursing until the 1950s when Rogerian theory gained attention in the counselling field as a client-centered
approach which encompassed humanistic approaches and the use of specific communication techniques (Gould, 1990). Specifically, nursing turned its attention to empathy after Carl Rogers' address to the American Nurse's Association in 1957 regarding the essential elements of a therapeutic relationship which reflected his focus on empathy as a key ingredient (Morse et al., 1992). Empathy has since been identified as a key component in caring relationships in nursing (Burnard, 1988; Clay, 1984; Forsyth, 1980; Gould, 1990; Holden, 1990; LaMonica, 1983; MacKay et al., 1990; Mynatt, 1985).

Leininger (1984) argues that "care is the central, dominant and unifying focus of nursing" (p.84). She adds that "caring is nursing, and caring is the critical factor that makes a difference in health maintenance and recovery from illness" (p.92). Benner (1984) emphasizes the caring component of nursing practice in her descriptions of the expert nurse. The importance of caring as a basis for nursing is undeniable, and the recognized vehicle for communicating care to the client is empathy (Clay, 1984; Forsyth, 1979; Gould, 1990; Holden, 1990).

To be effective, empathy involves the ability to "feel into" the thoughts of another while maintaining separateness. But beyond this, the helper's perceptions must be communicated to the helpee in such a way that the person not only becomes aware of this level of understanding on the part of the helper, but is also able to use this understanding as a means of expanding awareness and growth. This denotes the therapeutic aspect of the use of empathy in a helping relationship.
The use of the term empathy has been questioned because of its poor conceptual clarity. Conceptual clarity is lacking throughout the literature on empathy, from the viewpoint of counselling, psychology, and psychiatry as well as nursing. Pike (1990) points out the confusion as to whether empathy is a tool which can be used to objectively analyze another’s situation and thus enhance the development of a therapeutic relationship, or whether empathy is seen as the ultimate goal in the establishment of caring relationships. Pike cites Benner (1984) and Benner and Wrubel’s (1989) examples of clinical excellence, in which empathic understanding seems to encompass the whole relationship. In a response to Pike, Diers (1990) argues that it is dangerous to use the concept of empathy as an all-encompassing device to form the basis of a helping relationship. Instead, empathy should be thought of as a specific tool or a skill which can be used to enhance a helping relationship.

There is general agreement that empathy has two dimensions. *Trait* empathy refers to a general disposition, a cognitive awareness or attitude which can grow through experience (Alligood, 1992; Pike, 1990). It is expressed through a person’s feelings or thoughts about a given situation or through the general manner of dealing with others. *State* empathy refers to a specific skill that can be observed and quantified. It is expressed through spoken words. State empathy is built on a foundation of trait empathy (Alligood, 1992; Mehrabian & Epstein, 1972; Reynolds & Presley, 1988; Zderad, 1969). Both types of empathy are important to nursing. Knowledge of nurses’ trait empathy
provides information about their attitudes and disposition towards clients. As an attitude, empathy is seen as a broad concept which enables the helper to comprehend the state of another and to establish a relationship based on this understanding.

Many researchers have not made a distinction between two types of empathy but rather have identified the affective and cognitive components of empathy, both of which are needed for a truly empathic interaction to occur (Alligood, 1992; LaMonica, 1985; Olsen, 1991). Cognitive empathy refers to "intellectually taking the role or perspective of another person" (Gladstein, 1983). Goodyear (1979) adds that cognitive empathy has components of the properties of inference and intuition. Affective empathy involves being aware of the feelings that are being experienced by another, and because of previous experience, knowing what those feelings may be like for that person. These two dimensions of empathy are evident in both state and trait empathy.

Trait and state features are operationalized at different points in the three-stage process of empathy: (a) the helper's perception of a problem and readiness to offer empathy to a client (trait empathy), (b) the communication of an empathic response (state empathy), and (c) the client's perception that the helper is aware of the feelings and content which were expressed (affirmation of trait and state empathy) (Barrett-Lennard, 1976, 1981, 1993; Bennett, Legon, & Zilberfein, 1989; LaMonica, 1985; Olsen, 1991; Williams, 1990).
Measurement of Empathy

Difficulties in defining empathy have been the result of failing to recognize that it is a three-staged multi-dimensional construct, comprised of both state and trait features, and influenced by cognitive and affective components. This has led to many inconsistencies in measurement. Very few researchers have been specific about which stage of the empathic process was being studied or whether trait or state empathy was being measured. This adds to conceptual confusion and makes it difficult to compare results with other research in order to add to our empirical knowledge of empathy.

Measurement of Trait Empathy. The tools measuring the first stage of the empathic process concentrate on the professional's attitude or readiness to offer empathy and reflect trait empathy levels. Early attempts at measuring trait empathy sprang from the inception of the word itself as a reflection of feelings induced by viewing inanimate objects. Deutsch and Madle (1975) report that the psychologist Lipps was the first to test trait empathy in the very early 1900s using a crude measure that asked subjects to report their feelings while viewing an abstract picture. The measure of empathy was assessed directly by the number of responses expressed by the subject in response to the picture. Other early attempts at measurement of trait empathy concentrated on assessments of other people's movements or postures as an indication of how they may be feeling (Deutsch & Madle, 1975). Still other early tests measured trait empathy using a predictive scale developed by a psychologist (Dymond,
The scale consisted of four parts in which an individual (1) rated himself on six personality traits, (2) rated another individual on the same traits, (3) judged how the other would self-rate the characteristics, and (4) estimated how the other person would rate the subject. The test was designed to answer the question of how well the subject transposed himself into the thinking, feeling and acting of the other (Dymond, 1949). Hobart and Fahlberg (1964-1965) argued that this type of test failed to measure empathy and instead measured projection; i.e. the assignment of one's own feelings or opinions to another. Over the years, predictive tests have fallen out of favour and have been replaced by other direct measures of empathy.

Nurse researchers (Brown & Hunter, 1987; Brunt, 1985; Byrd, 1988; Floriani, 1980; Forsyth, 1979; MacDonald, 1977; Reynolds & Presley, 1988) have often used Hogan's Empathy Scale (Hogan, 1969) to measure trait empathy. This scale was developed by a psychologist to measure "an empathic disposition" (p.315). It consists of 64 items which measure social acuity, insight and perceptiveness from three different psychological and personality tests. It is used as a self-rating scale in which items are rated as either true or false by subjects assessing their own attitudes or usual behaviors.

LaMonica's Empathy Construct Rating Scale (ECRS) (1981) is also commonly used by nurse researchers to measure empathy (Bagshaw & Adams, 1986; Coffey & Swirsky, 1988; LaMonica, Wolf, Madea & Oberst, 1987; Murphy, Forrester, Price & Monaghan, 1992; Reynolds & Presley, 1988;
Rogers, 1986). Specifically, this 84-item scale was developed by a nurse researcher to provide an instrument that would measure the level of trait empathy evident in a helping relationship with clients. It can be administered as a self-report, peer-rating or client-rating scale.

Trait empathy scores for nurses have varied depending upon the instrument used. Brunt (1985) used Hogan's Empathy Scale to measure the trait empathy of 54 nurses working in a high technology environment (ICU) and found that all subjects displayed a low to moderate level of empathy. In contrast, most other researchers who measured trait (attitudinal) empathy levels found generally favourable results. Forsyth (1979) used the Hogan scale in his study of 70 nurses and results showed that trait empathy was in the "middle and upper levels of the range of possible scores" (p.5). Rogers (1986) used the ECRS in her study of 135 undergraduate nursing students and found that they possessed moderately well developed concern for others. Coffey and Swirsky (1988) also used the ECRS when studying the differences in trait empathy between hospital and visiting nurses (N=95) and found that there was a general trend toward well developed empathic attitude in all subjects.

The main problems with the use of tools designed to measure trait empathy have been related to researchers who attempted to use them to measure state empathy (eg. Reynolds & Presley, 1988). Critics argue that knowing a person's inclination to offer empathy does not guarantee that it will be used in practice (Gagan, 1983).
Measurement of state empathy. State empathy, the second stage of the empathic process, reflects skill in the practice of empathy and is assessed from the actual conversation patterns between helper and helpee. Scales and adaptations have been developed in the fields of psychology and counselling which rate the degree of empathy exhibited by the helper from non-facilitative to highly facilitative (Carkhuff, 1987; Gazda, Childers & Walters, 1982; Truax & Carkhuff, 1967). These scales have also been used extensively by nurse researchers to assess empathy in the nurse-patient relationship (Henderson, 1989; Hills & Knowles, 1983; Kalisch, 1971; La Monica, Carew, Winder, Haase & Blanchard, 1976; MacKay et al., 1990).

Truax and Carkhuff (1967) developed a 9-point scale, Truax's Accurate Empathy Scale, to rate a person's ability to use empathic communication according to descriptors ranging from 1 ("the therapist seems completely unaware of even the most conspicuous of the client's feelings") to 9 ("the therapist unerringly responds to the client's full range of feelings in their exact intensity") (Conklin & Hunt, 1975, p.121). The scale has been used most often by third-party trained judges who rate actual helper responses to a real or simulated client.

The scale was modified by Carkhuff (1969) who condensed the descriptors from nine to five points in order to reduce ambiguity and increase reliability. A cut-off score of 3 was established as the minimally facilitative level of empathy. Gazda further adapted the scale to four points and set a similar
cut-off level of 3. He established level four to indicate a degree of proficiency in which the helpee reaches a level of self-awareness that could facilitate self-help (Gazda et al., 1982).

A common problem with measuring state empathy involves obtaining high inter-rater reliability. As the empathic process is a subjective experience, it is difficult to establish an external evaluation of its quality. Various tactics such as clearly defining the unit of observation, carefully training judges and including helpee responses to verify state empathy have been tried to increase agreement among judges (MacKay et al., 1983). However, these efforts and the cost in time and money of taping and editing interactions makes this method a time-consuming and expensive proposition (Conklin & Hunt, 1975).

There is some evidence that state empathy levels are not as positive as trait empathy levels in nurses. LaMonica et al. (1976) studied the effects of a staff development program on nurses' state empathy. At intake, the majority of the 39 nurse participants (N=24) had scores below the facilitative level of state empathy as measured by Carkhuff's Indeces of Communication. Although the training program significantly increased the state empathy levels of the experimental group, as measured by Carkhuff's Indeces and Gazda's modification of Carkhuff's Scale, only three subjects reached a score of 3.0, which is considered minimally facilitative. The investigators suggested that this poor performance could be generalized to nurses as a whole and recommended that empathy training be included in basic nursing curricula, as
well as staff education programs. Hills and Knowles (1983), in a study of 47 medical-surgical nurses, found that 90% of the nurses scored below the minimally facilitative level on Carkhuff's Empathy and Respect Scales in response to simulated patient situations. MacKay and colleagues (1990) obtained similar findings during observations of 35 interactions between 12 nurses and their patients. Gazda's modified scale was used to rate the nurses' state empathy and again 98% of the nurses' responses were below the facilitative level. However, following an empathy training program, the same subjects were able to increase their state empathy scores in a laboratory setting to a barely facilitative level (from a mean rating of 2.075 for written responses to a mean of 2.975, and from a mean of 2.05 on verbal responses to a mean of 2.875). These increases were maintained as evidenced by laboratory testing seven months after completion of the program (MacKay et al., 1990).

Both trait and state empathy have been assessed using client-rating tools. Measurement of client responses to helper empathy reflects the third stage of the empathic process and provides confirmation of state or trait empathy in the helper. The most commonly used tool for this type of study is the Empathy subscale of the Barrett-Lennard Relationship Inventory (BLRI) (Barrett-Lennard, 1976). Several nursing studies of empathy have used this instrument (Hardin & Halaris, 1983; Kalisch, 1971; Stetler, 1977; Forsyth, 1979). The scale consists of 16 items on which the client rates the helper
according to a 6-point scale as to whether the statement about the helper is true (+3 descriptor) or untrue (-3 descriptor). It has been suggested that client-centered measurements are the most accurate indicators of true empathy in a helping relationship because they reflect true validation from the sender of the message. However as Barrett-Lennard (1976) states, this is "a logical rather than a theoretical proposition" (p.179). This method and its use in nursing research have been the target of much criticism in recent years. Some (Forsyth, 1979; Gagan, 1983; Gould, 1990) question the appropriateness of these client-centered tools because of their retrospective nature, and the often short-term nature of nurse-patient relationships in many hospital settings today. Long-term counselling relationships have served as the basis for the development of these client-centered tools, and patients who lack opportunity to develop long-term relationships with nurses may find it difficult to relate to some of the abstract statements posed by the instruments such as "She/he does not realize how strongly I feel about some of the things we discuss" (Gagan, 1983, p.68). Critics also argue that patients are a vulnerable group and social desirability may influence their responses to questions about nurses' empathy. Evidence suggests this concern may be well-founded as patients frequently report all nurses as empathic (Forsyth, 1979; Kalisch, 1971).

The failure to recognize and target a specific stage of the three-stage process of empathy jeopardizes the validity of many empathy scales. In addition, given that empathy is a subjective phenomenon, it is not surprising
that there is very little consistency in the perceived empathy levels among those giving, receiving or observing it in action. LaMonica (1981) found low correlations between self and peer ratings ($r = .10$, $p < .05$) and between peer and client ratings ($r = .06$, $p > .05$) of trait empathy when scores on the ECRS scale were compared. Contradictory results were also evident in Forsyth's (1979) exploratory study in which 70 nurses completed Hogan's Trait Empathy Scale and 70 patients chosen by the nurse participants completed the BLRI after at least three contacts with this nurse. The results showed that 50% of the nurses regarded themselves as having high empathic ability whereas 98% of the patients rated their nurses as highly empathic.

In sum, much controversy still exists surrounding the measurement of empathic ability. Given that empathy can be seen as a personality attribute (trait) or as a learned skill (state), it is important for the researcher to be specific in identifying the type of empathy being studied and to choose an instrument that appropriately measures this dimension.

In an effort to design an instrument which captures the multi-dimensional construct of empathy, Davis (1983) included four dimensions in his design of the Interpersonal Reactivity Index. The index includes subscales measuring perspective taking and fantasy, which he perceived to be related to cognitive empathy, and empathic concern and personal distress which he perceived were related to affective empathy. His failure to encompass the whole construct of empathy comes from not including a means of measuring state empathy. As
a result, his scale is not multi-dimensional but is a measurement of trait empathy.

**Patient outcomes related to nurse empathy**

Although "an environment of caring is believed to promote the overall well-being of patients and encourage healing" (Sherwood, 1995, p.63), very little empathy research has focused on patient care outcomes. LaMonica et al. (1987) studied 109 nurses and 656 patients in two medical and two surgical units in a major cancer center following an empathy skills training program in which 56 nurses participated. Patient responses were assessed by the Multiple Affect Adjective Check List and the LaMonica/Oberst Patient Satisfaction Scale. Patients being nursed by the experimental group who had had state empathy skills training showed significantly less anxiety and hostility, decreased depression, and increased satisfaction with care than the control group. Larsson and Starrin (1990) had questionable results in their study of nurse empathy and patient satisfaction among eight assistant nurses with 32 schizophrenic patients. Measures of trait empathy were made by assessing patients' and nurses' reactions following an encounter, using a Faces Scale. Results showed that patients were generally more cheerful following interactions with the "high empathy" nurses, measured in terms of higher correlations between nurse and patient appraisal. Murphy et al. (1992) used LaMonica's ECRS to study the trait empathy levels of 60 ICU nurses and their ability to assess family needs as measured by 92 family members of ICU
patients completing a critical care needs assessment tool (CCFNI). Nurses with higher trait empathy were found, through multiple regression analysis, to be more likely to meet six of the 30 needs assessed. These involved accessibility to the patient and information concerning the patient's condition. These nurses were also more likely to be thought of as flexible with visiting regulations.

Non-empirical nursing literature has some evidence of positive patient outcomes related to nurse trait empathy. Clarke (1986) recounts a story of a patient who credited her with saving his life simply by 'being there' and showing concern for him. Jezerski (1989) and Murphy (1986) also give accounts of encounters with empathic nurses and of the positive outcomes for the recipients of this type of care. Johnston-Early (1983) describes a cancer ward in which staff are encouraged to develop and are praised for involving themselves in relationships with their patients. She states that "Empathy is the unit's most valuable characteristic" (p.1182) as it enables nurses to "not only give care, they develop care" (p.1183). Jones (1990) emphasizes the importance of trait empathy in the care of patients with AIDS as being critical. Nursing literature is beginning to reflect the importance of trait empathy in nurses as a positive influence in patient outcome.

The only study which looked specifically at nurse state empathy in relation to patient outcome was done by MacKay and colleagues (1990). In their study of 12 nurses in 35 nurse-client interactions, nurse state empathy was studied in relation to incidences of patient self-disclosure. Higher levels of
state empathy were found in the nurses with higher frequencies of client self-disclosure.

**Influencing factors**

Researchers of nurse empathy have examined many variables for their influences on nurses' trait or state empathy. Certain variables (age, experience, gender, education, empathy training programs, work environment) have been shown to have an influence on nurse empathy.

**Age of the nurse.** Personal attributes of the nurse were considered in relation to empathy levels by several researchers. Common across the studies which looked at age in relation to both trait and state empathy levels was the finding that the age of the nurse was negatively correlated with the attitude and skill of empathy. Byrd (1988) tested a systematic randomized sample of registered nurses \(N=242\) and examined trait empathy as it related to practice area and years of experience. Her findings, using Hogan's Empathy Scale, showed a significant negative correlation between the age of the nurse and the level of trait empathy. Other studies assessing both trait (Forsyth, 1979; Reid-Ponte, 1992) and state (Mynatt, 1985; Pennington & Pierce, 1985) empathy reported similar findings.

**Experience.** Studies looking at years of experience in nursing and the level of trait empathy showed a negative correlation. Reid-Ponte (1992) attributed this finding to the fact that nurses with greater experience (>10 years) rely more on intuition to make decisions regarding care and less on specific
messages conveyed during interactions with patients. Brunt (1985) found that the trait empathy scores were negatively correlated with the length of time spent working on the same unit and not necessarily with years spent in nursing. Byrd's (1988) study of nurses from a variety of practice settings had similar findings and she suggested that nurses who worked in the same environment for an extended period disengaged from their work which was manifested either as high anxiety and overinvolvement or noninvolvement and avoidance behaviors.

Mynatt (1985) suggests that her findings of a negative correlation between years of experience and state empathy may be a reflection of the stressors in the workplace as well as the fact that rewards in the clinical setting are more often given for the completion of technical tasks rather than developing relationships with patients. Pennington and Pierce (1985) attributed their similar findings among nursing home employees to either burn-out (emotional isolation due to stress) or rust-out (isolation due to boredom), or possibly a combination of both.

**Gender.** Because of the traditionally greater proportion of females in nursing, gender has not been a highly studied variable. MacDonald (1977) compared the trait empathy levels of four groups of students (men in nursing, women in nursing, men not in nursing, and women not in nursing, N=15 in each group) using Hogan's Scale. He found that male students' trait empathy levels were significantly higher than female nursing students. Forsyth's (1979) study
of trait empathy among 70 nurses found that "the few" males in the study scored consistently higher than the females.

Becker and Sands (1988) studied empathy in relation to demographic variables in a group of 35 (F=29, M=6) junior nursing students. They used Davis' Interpersonal Reactivity Index to measure trait empathy and found that although males scored higher, the results were not statistically significant. The investigators suggested that males with higher social acuity were those who were attracted to nursing.

Communication skills training. There is ample evidence that a nurse's trait and state empathy can be influenced and enhanced through empathy-building skills (Burnard, 1988; Byrd, 1988; Clay, 1984; Daniels, Denny & Andrews, 1988; Henderson, 1989; Hills and Knowles, 1983; Hodges, 1991; Kalisch, 1971; LaMonica, 1983; LaMonica et al., 1976; LaMonica et al., 1987; Morath, 1989; Norris, 1986; Reynolds & Presley, 1988; Rogers, 1986).

Effects of communication skills training on trait empathy were assessed by several researchers. Daniels et al (1988) used the ECRS as an outcome measure only and administered it to nursing student subjects following microtraining in communication skills (N=53). Significant differences were shown between the experimental and control groups, however there were no measurements of trait empathy done prior to the initiation of the training. LaMonica et al. (1987) used the ECRS as a pre and post-test measure, and found no significant results following an empathy training program. Reynolds
and Presly's (1988) study of nursing students (N=79) used Hogan's scale to measure differences in trait empathy pre and post skills training and found no significant differences, however they also administered the ECRS as a measure of what they called state empathy, and found significant differences in one college under study (N not given). The largest (N=242) study (Byrd, 1988) which looked at trait empathy in relation to communication skills training showed that nurses who had had communication skills taught in their basic nursing program had significantly higher levels of trait empathy than those who did not, but that recent inservice education did not affect trait empathy levels. The investigator attributes this finding to the possibility that these skills need to be practiced for a period of time before they are internalized and become part of the trait of the helper.

Other researchers who examined the effect of communication skills training on the empathy levels of nurses assessed the effects on state empathy. These studies consistently showed that training in communication skills had a positive effect on nurses' state empathy levels. Hills and Knowles (1983), in their study of 47 registered nurses' state empathy using Carkhuff's Indeces of Communication and videotapes found that those nurses who had had supervised practice of interpersonal skills during their education scored significantly higher on state empathy than those who did not. Henderson (1989) and Daniels et al. (1988) both found that micro-training in basic communication skills increased the level of state empathy on Carkhuff's Index in the
experimental groups. Other research lends support to the evidence that empathic skills can be taught and that training in basic communication skills will positively affect the level of state empathy in the practicing nurse (Kalisch, 1971; LaMonica et al., 1976; LaMonica & Karshmer, 1978; LaMonica, 1983).

**Education.** The study of educational levels of nurses in relation to trait and state empathy has shown few conclusive results. Byrd (1988), in her study of 242 registered nurses, found no differences among the trait empathy levels of registered nurses from three different educational backgrounds (diploma, associate degree and B.N.) on Hogan's Empathy Scale. Forsyth (1979) reported that trait empathy levels on Hogan's scale increased as level of education increased. Baccalaureate nurses scored significantly higher than diploma graduates (N=70). Conversely, Reid-Ponte (1992), in her study of 65 primary nurses, found that as educational preparation increased, scores in perceiving, feeling and listening decreased, as measured by the LaMonica Empathy Profile assessing trait empathy. The investigator attributed this result to the possibility that better educated nurses performed roles that kept them away from the bedside and gave them less time to listen to patients.

Mynatt (1985) studied 20 students from each of four different types of nursing educational programs (diploma, associate degree, baccalaureate, and baccalaureate for registered nurses) and found no significant differences in state empathy levels as measured by a modified version of Truax's Relationship Questionnaire.
Work Environment. One variable of interest to empathy researchers is that of work setting. Most studies found that the environment of nursing practice had no effect on trait empathy levels among nurses (Brunt, 1985; Byrd, 1988; Forsyth, 1979). Coffey & Swirsky (1988), however, found that visiting (home) nurses scored significantly higher than hospital nurses on the ECRS (N=95), which measures trait empathy. They noted that a higher number of the visiting nurses were younger and had higher levels of education than the hospital nurses which may have accounted for the differences. No studies measuring state empathy considered the effects of the work environment as a variable.

Little is known about how different nursing care delivery systems affect nurse empathy. The selection of a nursing care delivery model is influenced by many factors within the environment, including the values and beliefs of the stakeholders (Lendrum, 1994). Only one study compared nurses' empathy levels while working in differing nursing care delivery systems. Floriani (1980) measured the differences in trait empathy levels using Hogan's Empathy Scale between primary and team nurses (N=30). The comparisons using the Mann-Whitney rank ordered test (p=.05) showed no significant differences between the two groups but a question on the demographic questionnaire on prioritizing patient concerns showed that 93% of primary nurses considered that alleviating anxiety was more important than following a medical regimen. Only 53% of team nurses expressed this concern. The investigator attributed this result to the possibility that the primary nurses were more involved in direct contact with
the patient and as a result, the focus of the relationship was different. She interpreted this as perhaps a crude measure of empathy.

Considering the importance of empathy to nursing and the impact that a nursing care delivery system has on patient outcomes, it is critical that nurses choose a delivery system that supports nurse empathy. Two very different types of nursing care delivery systems being practiced in Canada today provide frameworks which promote different values in patient care. Functional nursing and primary nursing models are still widely used in hospitals in Canada today (Lendrum, 1994).

The functional method of delivering nursing care has its roots in industry and is based on tasks or responsibilities. This system emphasizes efficiency, production and division of labour and it operates under a centralized administration and control (Berger & Williams, 1992; Kozier, Erb & Olivieri, 1991). In this system, a head nurse or supervisor is responsible for all of the care given to patients on a particular unit. The work of the unit is delegated by the head nurse to individual nurses as a task assignment, such as administering all medications or treatments for the unit for one shift. Sundberg (1986) states that "the functional method is efficient but uses a technical, nonpersonalized approach to patient care" (p.100). Berry and Metcalf (1986) describe the task allocation system of delivering nursing care as "non-individualized" and that "notions of person, identity and of feelings have little or no place in such an ordering of work" (p.589).
The other type of nursing care delivery system prominent in today's health care system is *primary nursing*. In its pure form primary nursing means that one nurse, in collaboration with "the patient, family, and other members of the health care team, assesses, plans, implements and evaluates the patient's nursing care from admission through to discharge" (Reed, 1988, p.384). Each nurse carries a patient load of approximately four or five patients and is accountable for the nursing care they receive on a 24-hour basis. In the absence of the primary nurse, an associate nurse is assigned to provide the nursing care using the care plan devised by the primary nurse (Reed, 1988).

Marie Manthey (1988) maintains that the essence of primary nursing is the relationship which exists between a nurse and a patient. She describes it as a "responsibility relationship....established by an RN who explains her role to the patient. That's all it is and that is everything that it is" (p.55). She also describes it as "the establishment of a therapeutic relationship" (Manthey, 1989, p.23). She believes that the expectations of a delivery system will dramatically affect the way a nurse practices, whether it be in the use of knowledge and learned skills or in verbal interactions with patients (Manthey, 1990).

Several studies have compared differing types of nursing care delivery systems and a few focussed on comparing the differences specifically between primary nursing and functional types of delivery systems. Sellick, Russell, and Beckmann (1983) studied patient and nurse satisfaction on one functional (28 patients, 17 nurses) and one primary nursing unit (31 patients, 20 nurses).
Patients' perception of the nursing care they received were measured on an instrument developed by the researchers. Results showed a higher mean rank on all 11 items on the Patient Satisfaction Scale for the primary nursing unit and significant differences on items which indicated that:

- nurses on the primary nursing unit were perceived to have a greater understanding of the patient..., showed more concern and communicated more with the patient's family..., were more likely to give information to the patient regarding his/her illness or condition..., tended to contribute more to a positive experience of hospitalization..., and gave greater consideration to discharge planning (p.270).

Results on the 23-item nurse job satisfaction scale showed that four items were significantly different in favour of primary nursing in comparison to functional nursing. These were (1) "the chances you have to accomplish something worthwhile", (2) "the opportunity to voice opinions", (3) "the chances you have to take part in making decisions" and (4) "I set the pace of my work" (p.271) while the one item which showed a significant difference in favour of functional nursing reflected a task-orientated approach - "I have to work very fast" (p.271).

The investigator noted that these findings coincided with the respective values inherent in the two types of nursing delivery systems. Felton (1975) used the Quality Patient Care Scale to examine quality of care when comparing a primary (19 nurses, 14 patients) and a team-functional (18 nurses, 16 patients) unit. Results showed a significant difference in favour of primary nursing on
psychosocial individual care which included such items as "Patient receives nurse's full attention" (p.29).

Although the patient outcome research admits to methodological problems (eg. of instruments lacking sufficient reliability and validity, difficulty controlling for extraneous variables) (Felton, 1975; Sellick et al., 1983), there is evidence that primary nursing, as opposed to functional nursing, does positively affect patient outcomes as a result of an improved nurse-patient relationship. The Sellick et al. and Felton studies, cited above, comparing primary nursing and functional nursing showed significant differences in patient satisfaction levels in favour of the primary nursing delivery model. Non-empirical literature also supports this connection. Horvath (1990) describes the improvement in nurse-patient relationships from both the nurses' and patients' point of view following a gradual implementation and refining of a primary nursing model. One nurse commented in an exit interview that "Primary nursing fosters interaction, not only with the patient, but with family as well" (p.225). Patients commented in unsolicited letters that the primary nurses' insight assisted in their adjustment to the illness experience. In his exploratory case study of the primary nurse's experience, Leach (1993) found that "much of the nurses' time was spent developing and maintaining effective interpersonal relationships with the patients" (p.398). He saw this as a "deliberate strategy and an essential part of the primary nurse's role" (p.398). Athlin, Norberg and Asplund (1990), interviewed 91 nurses concerning the experience of feeding 23 severely
demented patients in a task assignment system and found that nurses who were committed to their patients were much more likely to see the routine task as satisfying and rewarding. They went on to suggest that a change from a task-oriented system to a primary nursing delivery mode may increase this sense of commitment.

The values inherent in a nursing care delivery system may be an influential factor on nurse behavior particularly regarding the use of empathy. Very little research has focussed on how values influence the use of empathy. Research in psychology tends to show a link between altruism as a value and high levels of trait empathy (Batson & Oleson, 1991). Evans (1990) used a scale developed by Barrett to assess power as knowing participation in change in relation to nurse trait empathy among 254 public health nurses. Her results showed a significant correlation between the nurse's perceived power and trait empathy as measured by Hogan's scale. This result may indicate that the values of autonomy, responsibility and accountability inherent in primary nursing practice, which add to the nurse's perceived power in decision making, have a positive influence on nurses' trait empathy. Lendrum (1994) discusses the importance of identifying the values inherent within a nursing care delivery system in order to choose one that “inspires your nurses to care and provides them with a vision of their profession” (p.327).

Primary nursing has been discussed as an environmental condition that enhances the use of empathy in the nurse-patient relationship. Gagan (1983)
argues that there is an increasing commitment to a one-to-one relationship which is evident in primary nursing when compared with the often fractured relationships promoted by other types of delivery systems. Similarly, Gould (1990), argues that understanding and empathy are gaining more importance in the nurse-patient relationship as primary nursing is promoted and opportunities for interaction between patient and nurse are increased.

The establishment of caring relationships is still regarded as the backbone of nursing. Empathy has been identified as the critical dimension in the establishment of effective therapeutic relationships. Research has shown that empathy is multi-dimensional and can be assessed as part of the professional's personality, attitude or trait, or it can be assessed as a skill which indicates the professional's actual use of the dimension in practice. The measurement of empathy in nurses is a complex process. It is important to examine trait empathy as an indication of the general disposition towards the use of empathy in practice. This measure would include personality attributes, cognitive awareness of situations requiring empathy on the part of the helper, and would also be reflective of environmental influences on the attitude and inclination to use empathy in the nurse-patient relationship. As previously stated, the use of state empathy is based on a foundation of trait empathy. Therefore, state empathy is unlikely without a strong base of trait empathy. More knowledge may be gained in investigations of possible influences in the environment by initially choosing to measure trait empathy as an indication as
to whether attitudes have been influenced by certain variables.

Many factors have been shown to influence nurse empathy. Environmental influences may include the type of nursing care delivery system in which the nurse is practicing. There is some evidence that patient outcomes are more favourably influenced with increased empathy levels in primary nursing care delivery (Gagan, 1983; Gould, 1990). If there is a nursing care delivery system that promotes patient contact, opportunity to develop a caring relationship and thus opportunity to use empathy as an effective communication tool, then nursing should use and support the model. By determining whether differences exist in nurse empathy in settings where functional and primary nursing are practiced, nurses will gain an increased understanding about the environmental influences that support/undermine nurse empathy.

The purpose of this study was to compare the trait empathy levels of nurses working in a functional nursing care delivery system with those of nurses working in a delivery system using a primary nursing philosophy.
CHAPTER II

Methodology

Objectives and Hypotheses

This study examined differences in trait empathy levels between nurses working in two different types of nursing care delivery systems - functional nursing and primary nursing.

Hypotheses for this study were as follows:

1. The mean trait empathy level of the nurses working under the primary nursing philosophy will be significantly higher than the mean trait empathy level of the nurses working under the functional nursing care delivery system.

2. There will be a significant correlation between trait empathy scores and individual and workplace values. It is expected that higher scores on trait empathy will be correlated with higher scores on items which correspond with the primary nursing philosophy (autonomy, accountability, and development of one-on-one relationships with patients) (items 1, 2, and 3 on the values questionnaire).

3. The age of the nurses will correlate negatively with the trait empathy scores.

4. The mean trait empathy level of the male respondents will be significantly higher than the mean trait empathy level of the female respondents.

5. The number of years of experience of the nurses will correlate negatively with the empathy scores.

6. There will be no significant differences in empathy levels between nurses
from different educational levels.

7. The mean trait empathy level of nurses who have had communication skills training in their basic nursing education will be significantly higher than the mean trait empathy level of those who have not.

Setting

The setting for this study was the medical-surgical units of two large teaching hospitals in New Brunswick. One hospital, which is operating at present with 420 beds, serves primary, secondary and some tertiary functions in the province's capital city. From its opening in 1977 to 1993, the nursing department operated with an all RN staff who adopted a primary nursing care philosophy and this type of nursing care delivery system continues to be practiced, despite the addition of nursing assistants to the staff in 1993. Nurses are responsible for the total care of their assigned patients, including medications and intravenous therapy for the shift which they are working. Continuity of care is promoted by maintaining the same assignment during a shift rotation. Nursing care plans are initiated by the nurse admitting the patient and updated as necessary by the assigned nurse. This type of system allows nurses to be in contact with assigned patients at several times throughout the day. Nursing units are managed by unit managers who assume many of the responsibilities of the role of head nurse, however it is the nurse assigned to the patient who confers with other members of the health care team, including the physician, regarding the care of assigned patients. This hospital is referred
to in this study as Hospital A and a copy of the nursing philosophy is attached (see Appendix A).

The second hospital is operating at present with approximately 500 beds and also provides primary, secondary and tertiary care in the province's largest city. It is a major referral center for oncology and cardiac services in New Brunswick. The nurses in this hospital practice under a functional type of nursing care delivery system. Nursing assignments are made by patient allocation. On each unit there is a medication nurse assigned for the day to give medications to all patients. As well, in the hospital, there is an intravenous therapy team who initiate all intravenous therapy and give all intravenous drugs on the day shift. Assigned nurses give intravenous drugs on the evening and night shifts. Nursing care plans are initiated by the nurse admitting the patient and updated as necessary by the nurse assigned to the patient. Treatments are given by the assigned nurse who may also be responsible for covering the treatments to patients who have been assigned to a nursing assistant or orderly. As a result, patients may receive care from several nurses throughout any one shift which may reduce opportunities for meaningful relationships to be established on a one-to-one basis. The charge nurse on each unit assumes responsibility for co-ordinating patient care and consulting with other members of the health care team, including the physician, regarding patient care. The stated nursing philosophy of this institution promotes caring as an important value but gives no indication as to how the nursing care delivery system will
enhance the practice of this value (see Appendix B). This hospital is referred to as Hospital B in this study.

Sample

The target population for this study was registered nurses who have practiced full time in a general medical-surgical acute care area in one of the two above described hospitals with at least one year of continuous recent experience. Questionnaires were distributed on five units in each hospital - twenty to each unit. Power analysis with \( \alpha = .05 \) for a medium effect requires a population sample of 126 total when testing differences between two independent means, and a population of at least 88 is required for medium effect sizes in bivariate correlation computations (Polit, D. and Hungler, B.,1987). A total of 55 nurses completed or partially completed the questionnaires, 30 from the functional nursing care delivery system, and 25 from the primary nursing site.

Measurement

Trait Empathy

LaMonica's (1981) Empathy Construct Rating Scale (ECRS) was used to measure trait empathy and test hypotheses 1 through 7. This scale was chosen because it was developed by a nurse researcher, and had been used previously in studies of nurse empathy. As Alligood (1992) states, "the measurement of empathy in the nurse-patient relationship with instruments designed for other relationships may have contributed to lack of significance in
nursing research" (p.15). The instrument has proven reliability and validity and is derived from LaMonica's definition of empathy as a three part process. It was administered as a nurse self-report tool and as such was targeted at the first stage of the empathic process (i.e. nurse's perception of an expressed problem and readiness to offer empathy to a client).

LaMonica (1981) developed this scale from her belief that empathy is a necessary component of nursing. She is interested in how or whether this attribute is learned, in how the ability to offer empathy is maintained in nursing practice and what some of the effects of the use of empathy are on patient care. The original ECRS contained 100 items which were developed by soliciting statements from 25 female graduate psychology students and 25 female graduate nursing students about what they considered to be qualities of a highly empathic person and a person with very little empathy. The instrument contained five subscales: "(a) nonverbal behavior including body contact; (b) personality traits; (c) sensitivity to another's world; (d) responding; and (e) respect for self and others" (Evans, 1990, p.30). The scale has since been reduced to 84 items which have been shown through factor analysis and a multitrait-multimethod approach to be measuring a single construct, hence the original subscales which were identified have been deleted.

The scale is a paper and pencil self-administered report, which consists of eighty-four items that address an individual's feelings or actions towards another person. After reading each item, respondents decide the degree to
which they are like the statement. A 6-point Likert response scale ranges from extremely unlike (-3) to extremely like (+3).

Items are stated positively (forty-nine items) or negatively (thirty-five items) to decrease the likelihood of an acquiescent response set. The negative item scores are reversed and then all items are added to yield a score ranging from -252 (absence of empathy) to +252 (well developed empathy).

**Reliability.** To determine internal consistency, the instrument was given to a group of 103 female graduate nursing students. Fifty-four of the students were asked to complete the scale rating a person whom they knew who had the highest levels of empathy. The remaining forty-nine students were asked to rate the least empathic person they knew. The first group of responses had a coefficient alpha of .97; the second half had a coefficient alpha of .98. The split-half method corrected by the Spearman-Brown formula produced an $r = .89$ for the first group and an $r = .96$ for the second half (LaMonica, 1981). While investigating construct validity of empathy instruments, LaMonica (1983) reported a coefficient alpha for internal consistency of .96 for the ECRS based on a sample of 900 respondents. There is no evidence of test-retest reliability assessment. Bagshaw and Adams (1986) used the ECRS in a study of 363 nursing home personnel and calculated the Cronbach alpha reliability coefficient for the ECRS at .96. The reliability Cronbach alpha coefficient for the ECRS in this study was .97.

**Validity.** Validity testing for any instrument is a long process which is
accomplished over time by differing means. The original statements which formed this instrument were rated for content validity by three experts who were university professors in psychometrics, clinical psychology and nursing. They created an item pool of 259 items indicating a 7-point scale ranging from extremely well-developed empathy to total lack of empathy. The same pool of items was divided among 9 or 10 female graduate nursing students to be rated on the same scale. Items rated as unclear indicators of empathy by the panel of experts were deleted and combinations of the items remaining from both pools yielded a 100-item instrument with 46 items representing a lack of empathy and 54 items representing well-developed empathy (LaMonica, 1981).

A measure of construct validity for the instrument was accomplished by studying a sample of 173 registered nurses and 127 registered nursing graduate students. The ECRS was administered to the subjects in addition to seven other scales that examine similar concepts: (a) Carkhuff's Index of Communication, which is a situational self-report instrument measuring the Effective Communication-of-Empathy trait, (b) items from the California Psychological Inventory which measured the traits of sociability, social presence, sense of well-being, responsibility, self-control, tolerance, good impression, achievement via independence, intellectual efficiency, psychological-mindedness, and flexibility, selected for their consistency with the theoretical definition of empathy used for the development of the tool, (c) the Human Heartedness Questionnaire measuring the single trait of human-
heartedness or sympathy for the underdog, (d) the Chapin Social Insight Test which is used to assess a person's ability to recognize responses as defense mechanisms and the need for conflict resolution in group settings, (e) the Philosophy of Human Nature test, designed to assess expectations people have of another's behavior, (f) the Vocabulary Test-GT, a wide-range vocabulary test chosen because empathy theoretically involves a verbal response, and (g) the Tennessee Self-Concept Scale which measures self-concept across several areas. These scales were administered as self, client and peer-rating tools. The scales were factored and Campbell and Fiske's (1959) multitrait-multimethod matrix was used to examine convergent validity (seeing how closely the scale is related to other variables). Very low correlations between the ECRS and the other measures showed that convergent validity was not evident for the instruments used. This result indicates that the data gathered from different sources did not conceptually contribute to the definition of empathy, as had been indicated in the literature. LaMonica (1981) stated that this was evidence of the difficulties in defining empathy and that these difficulties will continue to pose problems for researchers attempting to isolate the concept and its effect on nursing practice.

Discriminant validity (seeing if the scale does not correlate with unrelated variables) of the ECRS was evident in the investigation between the Empathy-Self and the Empathy-Client scales of the ECRS (r=.20, p<.001). LaMonica interpreted this result as support for her definition of empathy as a three part
Another measure of construct validity was established through factor analysis. Results placed the entire instrument in the primary factor which suggests that all items in the scale are manifestations of empathy. The subscales originally developed by the investigator did not hold in factor analysis. The two principal factors which were identified by analysis of the ECRS were well-developed empathy and lack of empathy.

**Application**

The ECRS has been used by several nurse researchers in recent years. Various nursing populations have been studied using the instrument. Bagshaw and Adams (1986) used the scale to correlate nursing home nurses' empathy levels with their ideologic orientation towards custodialism and their attitudes toward the elderly. Other studies have used nursing students as the sample population in studies of how communication skills training changed empathy levels (Reynolds & Presley, 1988; Rogers, 1986). A number of studies used the scale to measure trait empathy changes as a result of interventions. A study by Daniels et al. (1988) measured the effects of communication skills training on nursing students using the ECRS as an outcome measure. Reynolds and Presley (1988) conducted a similar study in nursing students. Rogers (1986) administered the scale longitudinally to measure changes in undergraduate nursing students' empathy levels as they progressed through the nursing program. LaMonica et al. (1987) studied the effects of an empathy training program on registered nurses by having them complete the ECRS pre and
post-training.

Coffey and Swirsky (1988) were the only researchers to look at setting as a variable in their comparative study that examined the empathy levels of hospital and visiting nurses.

In a study looking at outcomes, Murphy et al. (1992) used the scale to compare the relationship between nurses' empathy levels and critical care family needs assessment.

Most of the researchers used the ECRS as a self-report measure of trait empathy, although this was not clearly stated. They indicated only that the instrument was being used to measure empathy. One researcher (Reynolds and Presley, 1988) mistakenly indicated that the instrument was being used as a self-report measure to assess state empathy.

Nurses' values

In addition to the principal instrument, a questionnaire was administered to assess the nurse's values that influence his/her practice and the nurse's perception of the values promoted in his/her work setting. This instrument was developed by the researcher under the guidance of a psychologist researcher with experience in instrument development. Content validity was addressed by choosing the values from the two nursing care delivery systems that were most evident in the literature (Berger & Williams, 1992; Horvath, 1990; Kozier et al., 1991; Leach, 1993; Lendrum, 1994; Manthey, 1988, 1989). The principal values of functional nursing chosen were efficiency, task accomplishment, and
division of labour. Those chosen to represent primary nursing were autonomy, accountability, and establishment of one-on-one relationships. A 7-point scale was used to determine the nurse's perception of those values influencing individual practice as well as those values that are promoted on the unit in which the nurse practices. Respondents were asked to circle the number which most closely corresponded to their agreement or disagreement with a statement about how each of these values influenced their individual practice, as well as their agreement or disagreement as to how much these values were promoted in the environment in which they worked. A high score (i.e. 18-21) on items 1, 2 and 3 in each grid indicated a preference for the values of primary nursing while a high score on items 4, 5, and 6 in each grid indicated a preference for the values of functional nursing. The instrument was critiqued by four professors of nursing for face validity. Because each value was assessed by only one item, internal consistency could not be tested. Reliability for this instrument is unknown. This instrument was used to test hypothesis 2 (see Appendix C).

**Demographic Data**

A demographic questionnaire (see Appendix D) was used to obtain information on age, sex, years of experience as a registered nurse, highest level of nursing education achieved, and whether communication skills training was included in basic nursing education. This information tested hypotheses 3 through 7.
Procedure

Questionnaires were distributed on each unit by the researcher at a time chosen by unit managers which was considered to be the most opportune time to speak to the nurses. All eligible nurses on each of these units were invited to participate in the study, and were recruited by a notice (see Appendix E) placed with the questionnaires, as well as through contact, where possible, with the researcher. Unit managers assumed some responsibility for distribution of the questionnaires to those staff members who were not present when the study was initiated. The questionnaires were left on the units for a period of three weeks. The researcher returned to the units after one week, and posted a new notice (see Appendix F) in order to draw attention to the uncompleted questionnaires. Because of feedback from some of the unit managers in the primary nursing hospital, a separate notice was posted on those units to attempt to explain the research procedure (see Appendix G).

A letter accompanied the questionnaire. It explained the purpose of the study and gave instructions to put the completed questionnaire in a marked and sealed box on the unit (see Appendix H).

After completion of the study, a general letter was sent to the units thanking nurses for participation in the study and informing them that a copy of the results will be sent to each hospital upon completion of the study. Because of the feedback from the primary nursing hospital, the letter to the units in that hospital was edited to address these issues. (see Appendix I and J).
Overview of Data Analysis

Data were analyzed using the SPSS statistical package. Scores on the ECRS and the values questionnaire were computed for individual respondents and were analyzed according to the hypotheses statements. The analysis of variance (ANOVA) was used to test hypotheses 1, 6 and 7. The analysis of variance tested the differences in individual score means between groups of nurses from different nursing care delivery systems, different educational backgrounds and different types of communication skills training. The Pearson Product-moment correlation was used to test hypotheses 2, 3, and 5. Relationships among the variables of age, years of experience, scores on the ECRS as well as the values questionnaire were determined with these continuous variables. An alpha level of .05 was used for all analyses.

Ethical Concerns

Permission was obtained from Dr. E. LaMonica for the use of the ECRS for measuring empathy levels (see Appendix K). Ethical approval was obtained from the ethics committees of both hospitals included in the study and Dalhousie University Graduate Studies Ethics Committee.

Participants were not required to give names and were informed that participation was voluntary and that they could elect not to answer some or all questions. They were also told they could withdraw at any time without any repercussions from the hospital and that there was no known risk involved with being a participant. After completion, the questionnaires were placed in a
sealed box which was placed on each unit. Participants were made aware that their contribution could help to build knowledge concerning how nursing care delivery systems affect nursing practice.
CHAPTER III

Results

Description of the Sample

Fifty-five registered nurses (54 female and 1 male) participated in this study. One hundred questionnaires were distributed in each of two hospitals and 55 responses (27.5%) were returned. Some questionnaires were incomplete (i.e. unanswered questions) and depending on the variable being measured, the responses from between 47 to 55 participants were analyzed for this study.

The age of the participant nurses ranged from 21 to 61 years with a mean age of 36.9 years. The years of continuous recent full-time experience for the respondents ranged from 1 year to 31 years with a mean of 10.5 years, while the total years of full-time experience for each respondent ranged from 2 years to 32 years with a mean of 12.37 years. Of the 55 respondents, 42 (76%) were prepared at the diploma level, 9 had received their basic nursing education at the baccalaureate degree level, and 4 had completed a diploma program and a subsequent university degree in nursing for a total of 13 BN graduates (24%). Forty three of the respondents reported that they had received communication skills training as part of their basic nursing education while 12 respondents had received no such training. The specifics of this training were not elicited by the questionnaire. Given the broad nature and scope of this type of training typically found across nursing programs, much
variance could be expected in the type of communication skill training received. Forty two of the respondents reported having had an opportunity to practice communication skills and receive feedback on their efforts; 13 of the respondents had no such opportunity. Forty two of the nurses stated that they had specifically practised empathy as a skill, and 13 stated that they had not had this opportunity. A limitation of the study was that no assessment was made regarding previous experiences with trait empathy - either as being taught or measured. Twenty of the respondents claimed to have attended a workshop on communications (specific nature unstated) within the past 1-4 years.

Statistics showed no significant differences between the populations from the two hospitals in the demographic variables of age ($t (52)=-.29, \ p=.77$), total number of years of experience ($t (45)=-1.62, \ p=.112$), education ($\chi^2(2)=2.086, \ p=.352$), or history of communication skills training ($\chi^2(1)=1.026, \ p=.310$).

**ECRS Results**

ECRS scores were analyzed from 48 of the respondents due to incomplete data from 7 of the respondents on the questionnaire. The possible range of scores is -252 to +252. The mean score on the ECRS for respondents ($N=48$) was 162.16, with a range from 60 to 223. The mean score for the nurses from the primary nursing delivery system was 157, while the mean score for the nurses from the functional delivery system was 166.
Values Questionnaire Results

Data from 53 respondents were analyzed for values preferences. Data from 2 respondents were incomplete. The mean score on the questionnaire which measured the respondents' preferences for values in this study was 32.6 (range from 20 to 42) for the primary nursing values (individual and organizational combined). On the functional nursing values (individual and organizational combined), the mean was 27.73 (range from 15 to 36).

A summary of the statistics for scores according to the two delivery systems is shown in Table 1.

Table 1
Descriptive Statistics for the ECRS, Primary Values and Functional Values Measures by Location.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Possible Range</th>
<th>N</th>
<th>Mean</th>
<th>Actual Range</th>
<th>N</th>
<th>Mean</th>
<th>Actual Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECRS</td>
<td>-252 to +252</td>
<td>21</td>
<td>157</td>
<td>60 to 223</td>
<td>27</td>
<td>166</td>
<td>81 to 223</td>
</tr>
<tr>
<td>Primary Values</td>
<td>7 to 42</td>
<td>23</td>
<td>33</td>
<td>26 to 42</td>
<td>27</td>
<td>31</td>
<td>21 to 41</td>
</tr>
<tr>
<td>Functional Values</td>
<td>7 to 42</td>
<td>22</td>
<td>25</td>
<td>15 to 32</td>
<td>30</td>
<td>29</td>
<td>19 to 36</td>
</tr>
</tbody>
</table>
Hypotheses Findings

Hypothesis 1

Hypothesis 1 predicted that the mean trait empathy level of nurses working in the primary nursing delivery system would be significantly higher than the mean trait empathy level of the nurses working in the functional nursing care delivery system. Analysis of variance showed that there was no significant difference between the two groups on trait empathy score ($E(1,46)=.506$, $p=.480$) (Table 2). The nurses practising in the primary nursing care delivery system did not have higher trait empathy levels than those working in the functional nursing care delivery system. Hypothesis 1 was not supported.

Table 2
Summary of ECRS Scores According to Nursing Care Delivery System

<table>
<thead>
<tr>
<th>Hospital</th>
<th>N</th>
<th>Mean</th>
<th>S.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Primary)</td>
<td>21</td>
<td>157$^a$</td>
<td>49.25</td>
</tr>
<tr>
<td>B (Functional)</td>
<td>27</td>
<td>166.18$^a$</td>
<td>40.21</td>
</tr>
</tbody>
</table>

Note.
$^a$ possible range -252 to +252
ANOVA ($E (1,46) = .506, p = .48$)

Hypothesis 2

Hypothesis 2 predicted a significant correlation between trait empathy scores and individual and workplace values. Higher scores on the ECRS were hypothesized to correlate with higher scores on the primary nursing values.
(accountability, autonomy, and establishment of one-on-one relationships).

Pearson Product-moment correlations demonstrated no significant relationships. In other words, preference for primary nursing values did not indicate a higher score on the ECRS (Table 3). Hypothesis 2 was not supported.

Table 3. Summaries of Correlations Between ECRS Scores and Values Scores.

<table>
<thead>
<tr>
<th>Values</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Individual</td>
<td>.05</td>
<td>.727</td>
</tr>
<tr>
<td>Functional Individual</td>
<td>.13</td>
<td>.407</td>
</tr>
<tr>
<td>Primary Organizational</td>
<td>-.09</td>
<td>.530</td>
</tr>
<tr>
<td>Functional Organizational</td>
<td>.06</td>
<td>.682</td>
</tr>
<tr>
<td>All Primary Values</td>
<td>-.04</td>
<td>.774</td>
</tr>
<tr>
<td>All Functional Values</td>
<td>.11</td>
<td>.475</td>
</tr>
</tbody>
</table>

Note: N = 46

Hypotheses 3 and 5

These hypotheses were concerned with the relationship between age, years of experience and scores on the ECRS. Pearson Product-moment correlations were used to test these hypotheses. Although the variables of age and total years of experience in nursing were negatively correlated with scores...
on the ECRS, the correlation was very modest and not significant (Table 4). Hypotheses 3 and 5 were not supported.

Table 4
Correlations between ECRS Scores and Variables of Age and Experience.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>48</td>
<td>-.16</td>
<td>.265</td>
</tr>
<tr>
<td>Years of Continuous</td>
<td>44</td>
<td>.13</td>
<td>.394</td>
</tr>
<tr>
<td>Recent Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Years of Experience</td>
<td>41</td>
<td>-.02</td>
<td>.912</td>
</tr>
</tbody>
</table>

**Hypothesis 4**

Hypothesis 4 stated that males would score significantly higher on the ECRS than female respondents. There was one male respondent in the study, and the ECRS score and other values were similar to the other respondents, therefore no statistical data were obtained.

**Hypothesis 6**

This hypothesis stated that there would be no significant difference on the ECRS scores among nurses from different educational backgrounds. Results on the ANOVA comparing nurses from different educational levels showed no significant differences ($E(1,46)=.31, p=.580$)(Table 5). Nurses who had received their basic nursing education in a diploma nursing program did not achieve significantly different scores than nurses who had received their nursing education in a baccalaureate program. This result may have been
influenced by the small number of respondents with baccalaureate degrees (N=10), which may not have been representative of the population. Hypothesis 6 was supported.

Table 5

Summary of Comparisons Between ECRS Scores and Different Educational Backgrounds.

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>N</th>
<th>Mean ECRS Score</th>
<th>S D</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Diploma</td>
<td>38</td>
<td>164.00</td>
<td>42.66</td>
</tr>
<tr>
<td>Bachelor of Nursing (basic and post-RN)</td>
<td>10</td>
<td>155.20</td>
<td>50.52</td>
</tr>
</tbody>
</table>

Note: ANOVA: F(1,46)=.31, p=.580

Hypothesis 7

Hypothesis 7 stated that the mean trait empathy scores of the nurses who had had communication skills training would be significantly higher than those who had not had training. Results on ANOVA (Table 6), showed no significant differences in ECRS scores between nurses who had had communication skills training and those who had none (F(1,46)=.79, p=.380). Communication skills training was not evident as a predictor of trait empathy scores. Hypothesis 7 was not supported.
Table 6
Summaries of ECRS Scores Between Variables of Communication Skills Training.

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>N</th>
<th>ECRS Mean</th>
<th>SD</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication skills as part of basic nursing education</td>
<td>yes</td>
<td>37</td>
<td>159.0</td>
<td>39.0</td>
<td>$F = .79$</td>
</tr>
<tr>
<td></td>
<td>no</td>
<td>11</td>
<td>172.5</td>
<td>57.6</td>
<td>$p = .380$</td>
</tr>
<tr>
<td>Practice of skills with feedback</td>
<td>yes</td>
<td>36</td>
<td>157.0</td>
<td>39.9</td>
<td>$F = 2.02$</td>
</tr>
<tr>
<td></td>
<td>no</td>
<td>12</td>
<td>177.6</td>
<td>53.7</td>
<td>$p = .162$</td>
</tr>
<tr>
<td>Learning to use empathy as a communication tool</td>
<td>yes</td>
<td>36</td>
<td>160.4</td>
<td>41.2</td>
<td>$F = .23$</td>
</tr>
<tr>
<td></td>
<td>no</td>
<td>12</td>
<td>167.5</td>
<td>53.8</td>
<td>$p = .634$</td>
</tr>
<tr>
<td>Attending a workshop on communication skills</td>
<td>yes</td>
<td>16</td>
<td>169.6</td>
<td>38.9</td>
<td>$F = .68$</td>
</tr>
<tr>
<td></td>
<td>no</td>
<td>32</td>
<td>158.4</td>
<td>46.7</td>
<td>$p = .413$</td>
</tr>
</tbody>
</table>

Note: All df = 1.46.

Additional Findings

Nurses responding to the values questionnaire (N=54) rated all of the values fairly high, with the exception of value # 6 (the assignment of one task for all patients associated with functional nursing). Significant differences were noted in favour of functional nursing on the individual and organizational value...
of assigning one task for all patients. Significant differences were noted in favour of primary nursing on the organizational value of autonomy. (Tables 7 and 8).

Table 7
Scoring of Individual Values and Differences Between Delivery Systems

<table>
<thead>
<tr>
<th>Individual Values</th>
<th>Hospital A (primary)</th>
<th>Hospital B (functional)</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accountability</td>
<td>5.37</td>
<td>5.46</td>
<td>$F=.05$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p=.826$</td>
</tr>
<tr>
<td>2. Autonomy</td>
<td>6.00</td>
<td>5.83</td>
<td>$F=.28$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p=.597$</td>
</tr>
<tr>
<td>3. Development of one-on-one relationships</td>
<td>6.00</td>
<td>6.30</td>
<td>$F=1.45$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p=.232$</td>
</tr>
<tr>
<td>4. Fair division of work</td>
<td>6.29</td>
<td>6.43</td>
<td>$F=.25$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p=.621$</td>
</tr>
<tr>
<td>5. Efficiency</td>
<td>6.29</td>
<td>6.60</td>
<td>$F=2.04$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p=.158$</td>
</tr>
<tr>
<td>6. The assignment of one task</td>
<td>1.82</td>
<td>3.03</td>
<td>$F=8.94$</td>
</tr>
<tr>
<td>for all patients</td>
<td></td>
<td></td>
<td>$p=.004^*$</td>
</tr>
</tbody>
</table>

Note:
ANOVA - all df 1,52
possible range of scores 1 - 7
* significant findings
Table 8
Scoring of Organizational Values and Differences Between Delivery Systems

<table>
<thead>
<tr>
<th>Organizational Values</th>
<th>Hospital A (primary)</th>
<th>Hospital B (functional)</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accountability</td>
<td>5.50</td>
<td>4.70</td>
<td>F=3.69 p=.060</td>
</tr>
<tr>
<td>2. Autonomy</td>
<td>5.70</td>
<td>4.53</td>
<td>F=7.95 p=.007*</td>
</tr>
<tr>
<td>3. Development of one-on-one relationships</td>
<td>5.37</td>
<td>4.70</td>
<td>F=2.63 p=.111</td>
</tr>
<tr>
<td>4. Fair division of work</td>
<td>5.29</td>
<td>4.60</td>
<td>F=3.25 p=.077</td>
</tr>
<tr>
<td>5. Efficiency</td>
<td>5.00</td>
<td>4.80</td>
<td>F=.19  p=.661</td>
</tr>
<tr>
<td>6. The assignment of one task for all patients</td>
<td>1.12</td>
<td>3.76</td>
<td>F=43.20 p=.001*</td>
</tr>
</tbody>
</table>

Note:
ANOVA - all df 1,52
possible range of scores 1 - 7
* significant findings

When the values were combined, nurses working in the functional nursing care delivery system scored significantly higher on the individual functional values (fair division of work, efficiency, and task assignment - items 4, 5, and 6 in the questionnaire) than the nurses working in the primary nursing system (F(1,50)=5.73, p=.0204). There was no significant difference between
nursing care delivery systems noted on the ratings of the organizational functional values. Conversely, the primary nursing system respondents scored significantly higher on the organizational primary nursing values (accountability, autonomy, establishment of one-on-one relationships - items 1, 2, and 3 in the questionnaire) than the nurses from the functional nursing system ($F(1,51)=4.95, p=.0304$). There was no significant difference on the individual primary nursing values between the two groups. When all of the primary nursing values were combined (personal and organizational), there was no significant difference between the two groups, however when all of the functional values were combined, the nurses from the functional nursing care delivery system scored significantly higher on this total ($F(1,50)=7.05, p=.0106$). Table 9 presents a summary of these findings.
Table 9
Summary of Values Ratings According to Delivery System.

<table>
<thead>
<tr>
<th>Values</th>
<th>Hospital A</th>
<th></th>
<th>Hospital B</th>
<th></th>
<th>ANOVA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Nurses</td>
<td>Functional Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>E</td>
<td>p</td>
</tr>
<tr>
<td>Primary Individual</td>
<td>17.2</td>
<td>3.2</td>
<td>17.7</td>
<td>2.2</td>
<td>0.57&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.330</td>
</tr>
<tr>
<td>Functional Individual</td>
<td>14.4</td>
<td>2.9</td>
<td>16.1</td>
<td>2.2</td>
<td>5.73&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.020&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
<tr>
<td>Primary Organizational</td>
<td>16.4</td>
<td>3.1</td>
<td>13.9</td>
<td>4.5</td>
<td>4.95&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.030&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
<tr>
<td>Functional Organizational</td>
<td>11.3</td>
<td>2.5</td>
<td>13.2</td>
<td>4.0</td>
<td>3.91&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.053</td>
</tr>
<tr>
<td>All primary</td>
<td>33.6</td>
<td>5.1</td>
<td>31.5</td>
<td>5.7</td>
<td>1.93&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.169</td>
</tr>
<tr>
<td>All Functional</td>
<td>25.6</td>
<td>4.4</td>
<td>29.2</td>
<td>5.2</td>
<td>7.05&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.010&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Note.
* significant findings
N range (primary Hospital A) 22-23
N range (functional Hospital B) 29-30
<sup>a</sup> df (1, 50)
<sup>b</sup> df (1, 51)
Several respondents made comments about the study which reflect the social context of the nurses' current work life. One comment made repeatedly criticized the length of questionnaires and the time needed to complete them. A suggestion that respondents complete the questionnaires at home was not greeted with any more enthusiasm. Leaving the job at the door is one of the major coping mechanisms many nurses use to manage the current stressors in the health care environment (Rogers 1995). Further, in the hospital practicing primary nursing, a few of the nurses openly expressed disapproval of some of the items on the trait empathy scale (ECRS). They did not like rating themselves using words such as “cruel” (as in item 13 in the ECRS). As one respondent wrote in the questionnaire “cruel and nursing are mutually exclusive!” This respondent did not complete any further items and wrote on the front of the questionnaire “I refuse to finish this questionnaire as it is an insult to me and the nursing profession!!” Another respondent from the same hospital did not even begin to complete the ECRS, but wrote on the front “This is ridiculous. We are not here to torture patients.” LaMonica included some negatively oriented items in the questionnaire to ensure that respondents did not engage in a response set. The way she worded these items has raised a critical point regarding instrument construction. The wording of the items should not be a critical factor in causing nurses to abandon the completion of the questionnaire, as seemed to be the case in this study. A notice was placed on the units in this hospital to explain the reasons for the wording of the
questionnaire (see Appendix G), but this did not alleviate the frustration. It did serve as an avenue for more venting of feelings however, as one nurse wrote on the notice “Why not try research that will help us in our daily struggle with patient care?? ..no need to think about these questions. They are totally irrelevant and inappropriate, especially these days...we are too busy to give any time to this type of research.” Another respondent expressed frustration with the number of similarly worded items writing “Questions are the same, just worded differently. Not a good use of nursing time!!”
Chapter IV
Discussion

This study was designed to compare the trait empathy levels of nurses working in two different types of nursing care delivery systems. LaMonica’s Empathy Construct Rating Scale was used to determine the trait empathy of the nurses. A values questionnaire, reflecting the values of the two types of delivery systems, was used to examine the nurses’ interpretation of which values influenced individual nursing practice as well as which values were promoted in the organizational environment in which this practice took place. A demographic questionnaire gathered information about individual career characteristics which were incorporated into the study.

The findings of this study did not support the hypotheses derived from the literature, with one exception. The educational level of nurses was found to have no significant effect on trait empathy. Varying results re education have been found in other studies. Forsyth (1979) found that as education increased, trait empathy as measured by Hogan’s scale increased. Reid-Ponte (1992), on the other hand, found that as education increased, scores in listening, feeling, and perceiving decreased. The largest study to date (Byrd, 1988) obtained similar results to this investigation and showed no significant difference among 242 nurses in trait empathy, as measured by Hogan’s scale, according to their educational level.

Other variables examined in this study (age, gender, years of
experience, history of communication skills training) provided no statistically significant findings. It was hypothesized that nurses working in a primary nursing care delivery system would have significantly higher levels of trait empathy than nurses working in a functional nursing care delivery system. Results from this study showed no significant difference, similar to Floriani’s (1980) study which compared trait empathy levels between nurses working in primary and team nursing delivery systems (N=30). Given that much nursing literature supports this hypothesis (Felton, 1975; Horvath, 1990; Leach, 1993; Sellick, Russell, & Beckman, 1983), it may be that indeed there is no difference, or the results may be due to measurement problems (eg. small sample sizes, choice of instrument, etc.) Another factor that may have influenced the findings of this study is the mix of respondents in the hospital practicing functional nursing. The nursing staff in this hospital was diluted somewhat within the past two years with staff from a smaller hospital in the same city which had been down-sized. Nurses from this smaller hospital had been practicing primary nursing before the move. Although they had practiced in the functional nursing system for at least a year, the influence of the primary nursing practice may have influenced some of the respondent’s scores. In conversations with staff in both hospitals, another possible influence on this study became evident. Nurses in each hospital do not see themselves as practicing according to any one pure delivery system. Nurses in the functional delivery system often describe their practice as ‘total patient care’, in which one nurse is responsible
for all of the care for an assigned group of patients for one shift (Kozier et al., 1991). Although nursing units in this hospital still delegate tasks to assigned nurses (e.g., medications, intravenous initiation and monitoring), perhaps the decentralization of lines of authority that have occurred as a result of program management have also been an influence on a very diluted example of functional nursing. In the other hospital under study, the director of nursing at the time of the study expressed her observation that the delivery system being practiced in this hospital may no longer be considered primary nursing, due to the influences of rapidly changing environments which have eroded consistencies in planning and commitment to the philosophy of primary nursing. She also used the term ‘total patient care’ to describe the type of delivery system being practiced (Schaller, E., personal communication, June, 1996). Given these considerations, perhaps the two nursing care delivery systems under study did not differ as much as textbook definitions would infer, and this may have been a great influence on the findings of this study.

It was hypothesized that age would be negatively correlated with trait empathy. A very modest negative correlation was evident in the findings of this study, however the result was not statistically significant (r = -0.164, p = 0.265). Byrd’s (1988) study of 242 nurses showed statistically significant negative correlations between trait empathy and age (r = -0.20, p = 0.001). Reid-Ponte’s (1992) results showed a significant negative correlation with only one aspect of the LaMonica Empathy Profile - that of verbal response, and Forsythe’s (1979)
study showed negative correlations between age and trait empathy scores, but results were not statistically significant (N=70). Again, the results of this study may have shown a more significant correlation with a larger number of respondents.

Years of experience were expected to correlate negatively with trait empathy scores as well, as had been shown in previous studies (Byrd, 1988; Forsyth, 1979; Reid-Ponte, 1992). Byrd's (1988) study may have shown statistically significant negative correlations because of the large sample size (N=242). Reid-Ponte's (1992) results showed that years of experience correlated negatively with only one aspect of the Empathy Profile - that of verbal response. Forsyth's (1979) study of nurse trait empathy using Hogan's scale found similar results to this study in non-significant negative correlations between empathy scores and years of experience (N=70).

It was hypothesized that nurses who had received communication skills training in their basic nursing education would have significantly higher trait empathy scores than those who had not. Findings showed that there was no significant difference in trait empathy levels between nurses who had received any type of communication skills training. Many studies looking at this variable measured state empathy, which reflects the skill of using empathy in practice (Burnard, 1988; Clay, 1984; Daniels et al., 1988; Henderson, 1989; Hills & Knowles, 1983; Hodges, 1991; Kalisch, 1971; La Monica, 1983; La Monica et al., 1976; Morath, 1989; Norris, 1986). State empathy was shown by these studies
to significantly increase following communication skills training. Studies looking at trait empathy changes following communication skills training were inconsistent. Daniels et al. (1988) found significant differences between experimental and control groups when ECRS scores were used as an outcome measure only following microtraining in communication skills in a group of student nurses (N=53). La Monica et al. (1987) found no significant differences on the ECRS when used pre and post training to measure trait empathy. Byrd's (1988) study showed the most conclusive results between communication skills training and trait empathy in practicing nurses. Results showed significant positive correlations between trait empathy and communication skills training in the nurse's initial educational program, however the trait empathy scores of nurses who had attended recent workshops in communication skills did not show a significant correlation. Again, the positive correlations may only have become evident in the larger sample size (N=242), and may have been more clearly demonstrated in this study with a larger number of respondents.

Social Context of the Findings

This study was conducted in two hospitals in New Brunswick in which many changes have occurred in the recent past. The most influential factor in environmental change has been health care reform and downsizing, which has been pervasive across Canada. Cuts in hospital beds have resulted in job losses and hospital closures (Kerr & MacPhail, 1996; McGeorge & Giberson, 1994). The basic principles guiding this reform include a focus on
health promotion, cost control, accountability, regionalization, a consumer focus and community-based services (Jackson, 1995). In New Brunswick, regionalization of the health care system took place in 1992. As a result, the management structure changed, and one Board became responsible for several hospitals within a Region. At the same time, hospital bed closures occurred at an alarming rate because of government's increasing emphasis on cutting expenditures. This led to closures of hospital units, some temporary and some permanent, and in some cases elimination of small hospitals altogether. The impact that these changes had on nursing staff was mainly a result of increased mobility of staff within regions, and a sense of insecurity as to which unit would be affected next. Both of the hospitals in this study have been able to avoid losses of full-time positions in nursing to this point, but this has resulted in much mobility within the regions (Schaller, E., McGill, B., personal communication, September, 1996). Part-time and casual nurses who had been filling full-time positions have been displaced in order that full-time nurses could keep a position.

These changes have had a big influence on the nurses' practice environment, particularly in hospitals. Nurses in acute care have been influenced by heavier patient loads and increasing acuity of care (Jackson, 1995). Shorter hospital stays have shortened the time that hospital nurses have to interact with their patients. Because of the greater emphasis on home care, patients who do remain in the hospital are often very ill requiring intense
bedside care, and are often too ill to engage in intensive therapeutic relationships with nurses. These changes have had an impact on nurses from both types of delivery systems. The nurses in the functional delivery system are finding themselves saddled with more responsibility as the task orientation becomes increasingly more complex - being responsible for treatments and medications for patients who are in the very acute stages of illness. The nurses in the primary nursing care delivery system are finding that their practice is being eroded by a shift in emphasis away from establishing meaningful relationships with patients and their families to administering safe care. A very recent newspaper article (White, 1996) recounts results of a study which has not yet been released to the public. It was conducted with the nurses from the hospital practicing primary nursing that was used in this study. Both studies occurred in the same time frame. The article quotes nurses as saying that “Increasing economic pressures, job loss and uncertainty are creating toxic work environments...patient acuity has increased dramatically...there just doesn’t seem to be time anymore to get to know your patients or to really do your job well” (White, 1996, pA1-A2).

A recent project undertaken by the Nurses Association of New Brunswick entitled “Personal Transitions In a Changing Work Environment” also uncovered many practicing nurses' frustrations with the present work environment (Rogers, 1995). With current patient loads, nurses find that they are not able to give the care that they value, which leads to a loss of
satisfaction with the job (Rogers, 1995). More frequent patient turnaround also leads to mixes on the units - patients are admitted wherever there is a free bed, and nurses often find themselves responsible for patients with conditions that they have not worked with before. In addition, nurses whose jobs have been displaced due to downsizing are often moved to units where they are unfamiliar with the types of patients and the level of nursing required. This leads to insecurity and unstable work environments, and even the nurses who are left on the units feel threatened by the changes. Rogers (1995) quotes one nurse as saying "'I don't mind the new faces as long as the old faces can stay'" (p.8). Often, nurses who are left untouched by down-sizing also must cope with 'survivor syndrome' - feeling guilty that the friend whom they have worked with for the past three years and has a family to support has been laid off. Nurses who are left in the system also have little or no chance at job mobility because of freezes on hiring. This leads to burnout and greatly increased dissatisfaction with the job and contributes to a shift in the nurse's focus away from meaningful relationships with patients. Another impact of economic restraint has been the hiring of lesser qualified personnel to take over many of nurses' former functions. The primary nursing hospital in this study, which had functioned with a totally RN staff since its inception in 1976, began hiring nursing assistants in 1993 (Schaller, E., personal communication, July, 1996). This change violated the philosophy of the primary nursing care delivery system, and changed the roles of the nurses working in the system. Registered nurses took on a more
supervisory role, which in turn lessened the time they spent at the bedside interacting with patients.

The two hospitals in this study also recently changed the administration of the institutions to program management, which can leave nurses feeling that they are losing their identity. There is no longer a nursing department as such in the hospitals, and this may lead to feelings of loss of support from management. Nurses are often left wondering “Who do I turn to?” in times of distress (Haines, 1993; Thomas, 1995).

Together these influences in the health care system leave nurses wondering about their ability to deliver quality care. As Rogers (1995) states, nurses have shifted their focus from quality care to safe care. She goes on to say that because nurses value quality care, many of them are exhausted, and are frustrated with the reality that they are no longer able to “give any extras” (p.8). White (1996) also noted that the provision of quality care was a primary goal identified by the nurses and they expressed great concerns about being able to continue to provide that care.

During the course of this research, the influence of this unrest became evident as some of the respondents used the questionnaires to vent their frustrations. The negative flavour of some of the responses elicited by this study may be reflective of nurses’ feelings while working in a system which offers staff nurses little power over changes that are occurring (Rogers, 1995). All of the comments noted on the instruments of this study came from nurses
working in the primary nursing delivery care system. Perhaps the nurses working in the primary nursing system are more accustomed to expressing themselves freely, as Sellick et al. (1983) found in their study comparing primary and functional delivery systems. The nurses working in the primary nursing delivery system rated significantly higher on "the opportunity to voice opinions" (p. 271) than the nurses from the functional delivery system.

An encouraging finding in this study was that the mean trait empathy score of all respondents was in the moderately high range, in spite of all of the negative influences in the environment, as described above. However, this result must be viewed with caution. It may reflect a general trend in both primary and functional nursing settings of good empathic attitudes, as more than 25% (30/100 in the functional nursing setting and 25/100 in the primary nursing setting) of the population in the units under study participated. Or, the results could mean that only those nurses with high trait empathy responded to the questionnaires. The relatively high scores may also be attributed to the administration of a self-report measure. Other studies using self-report measures of trait empathy had similar findings (Coffey & Swirsky, 1988; Forsyth, 1979; Rogers, 1986), and this may be an indication of the influence of social desirability.

In addition, all of the respondents (both those working in primary and functional settings) indicated a high regard for the values of autonomy, accountability, development of one-on-one relationships with patients,
efficiency, and fair division of work. Many of these values are hallmarks of professional behavior (Chitty, 1993; Creasia & Parker, 1996) and thus are indicators of a continuing high regard for the work that is nursing. All of the respondents (primary and functional nurses alike) showed a much lower rating for the value of assigning one task for all patients, which could be likened to assembly line work. This would indicate that nurses prefer to have more sustained contact with patients and provide complete care regardless of the nursing care delivery system in which they practice.

As expected, nurses working in the primary nursing delivery system scored significantly higher in the rating of primary nursing values held by the organization in which they worked, mainly related to the significant difference between the two groups on the promotion of autonomy in the environment. Sellick et al. (1983) had similar findings in that primary nurses rated significantly higher on organizational influences on practice (eg. “the chances you have to take part in making decisions”, p.271). This result may have been related to the nursing philosophies from the two hospitals which promote different values - the philosophy of Hospital A encourages a multi-disciplinary approach coordinated through primary nursing with an emphasis on responsibility and accountability creating a professional image for nursing, whereas the philosophy of Hospital B is more patient focussed with very little description of the role of the nurse within the system. However, there was no significant difference between the two groups in the rating of individual primary nursing values. This indicates that
nurses in both settings hold a high regard for the professional values of autonomy, accountability, and establishment of one-on-one relationships whether or not they believe that the practice environment supports these values.

The nurses working in the functional nursing care delivery system had higher ratings for individual functional values than those working in the primary nursing system, mainly due to the significant difference in the value of assigning one task for all patients. There was no significant difference in the ratings of all organizational functional values between the two groups, although the value of assigning one task for all patients was again statistically significant in favour of functional nursing.

When individual and organizational values were combined, all respondents showed a significant preference for the primary nursing values ($t(51)=5.99$, $p=.001$). With current shortages in nursing positions, and very limited job mobility, nurses do not choose to work in an area that matches their own nursing philosophy, but rather take a job wherever it is available. The results from this study suggest that these nurses are practicing primarily according to their own value systems, which are very similar, and thus significant differences in trait empathy as influenced by the delivery system were not evident.
Chapter V

Conclusions

Limitations of the Study

The following limitations may influence the generalizability of the findings of this study:

1. The number of respondents was not as great as anticipated. A limitation was imposed at the outset by Dr. LaMonica that only 200 copies of the principal instrument could be copied (see Appendix K). Perhaps a larger distribution of the questionnaire would have yielded a larger sample size. Efforts to recruit a larger sample size were exhausted and it became evident that further pressure on nurses to participate may only serve to bias the outcome.

2. In order to encourage more participation, attempts were made to alleviate some of the negative feedback that ensued following the distribution of the questionnaires. However, the wording of the notice that was posted in the hospital with the most negative response may have triggered even further problems because of the use of the word 'accuse' (see Appendix G). Nurses reacted to the notice with further negative feedback.

3. Several problems were noted with the principal instrument which may have contributed to the limited response. It was noted by several nurses that it was lengthy, and that the same questions were being asked in several different ways. Although the Cronbach alpha reliability coefficient result was excellent,
this result is not surprising with the number of items in the questionnaire. The inter-item correlations mean was .25 (minimum -.23, maximum -.93), which may indicate that the Cronbach alpha coefficient was artificially increased because of the 84 items in the questionnaire. Statistical theory shows that true variance increases according to the square of the number of items on the questionnaire, whereas the error variance increases only according to the actual number of items. This effect artificially increases the reliability co-efficient as the number of items increases (Streiner, D. & Norman, 1989). In an effort to increase the reliability of an instrument, it is often necessary to include several items that essentially answer the same question, but when respondents begin to be sensitive to this tactic as a waste of time, perhaps elimination of some of the items is a necessary consideration. In addition, the language of the questionnaire was challenged by some of the respondents. One nurse refused to finish the questionnaire after reading one item that used the word 'cruel'. This may be an indication that other respondents were negatively influenced as well and the completion of the questionnaire may have been coloured by this reaction. This instrument was created close to twenty years ago, and perhaps it was more appropriate to the nursing situation of that time period. Nurses today are perhaps more influenced by the constantly changing work environment, and also are encouraged to be more assertive in their responses to situations. In today's nursing environment, researchers need to be more sensitive to nurses' working conditions and their opinions of themselves as
professionals.

4. This study was conducted in two hospitals that were within access of the researcher. They may not have been truly representative of the two nursing care delivery systems under study. The results may have been different if two hospitals practicing pure examples of the nursing care delivery systems had been chosen.

**Implications For Nursing Practice**

Nursing is undergoing dramatic change as a result of cuts in health care budgets which have resulted in job losses, expanded roles, increasing acuity in patient care, and displacement by less skilled workers (Jackson, 1995). Under these conditions, the time and opportunity for a nurse to establish a therapeutic relationship with a patient are often at a premium. Yet a caring relationship is the essence of nursing and critical to health outcomes. One of the most effective means for demonstrating caring is through the use of empathy in attitude, behavior and conversation with patients and families (Carkhuff, 1969; Gazda et al., 1982; MacKay et al., 1990; Rogers, 1961).

Results of this study show that attitudes towards the use of empathy in practice are favourable in nurses regardless of the stresses of the working environment. Trait empathy levels in this study were in the moderately high range for all respondents, which may show that nursing's emphasis on developing an empathic approach persists even in troubling / challenging times. The nursing care delivery system was not shown to be a factor in determining
the nurses' attitudes towards the use of empathy in nurse-patient relationships. This result, however, does not preclude the implication that a primary nursing delivery system provides more opportunity for patient contact and thus improves nurse-patient relationships. Trait empathy is only one component of relationships between nurses and patients. There are other facets of these relationships which may, through research, show that they have been influenced by the delivery system (e.g., time spent with patients, state empathy, patient comfort, etc.).

Nurses working in both the primary and functional nursing care delivery systems showed a significant preference for the values inherent in the primary nursing delivery system model. This indicates that nurses prefer to practice in an environment that recognizes their autonomy, accountability and efforts to establish one-on-one relationships with their patients. This result implies that choosing this delivery system may lead to a more professional role for nurses - allowing them to make decisions regarding patient care which may mean more time for establishing therapeutic relationships with patients. The current state of the practice of nursing has been evidenced through the feedback of the respondents. Nurses want and need to be heard regarding their concerns about what is happening as a result of the health care changes so prevalent today.

Nurse administrators need to be made aware of the importance that practicing nurses place on attitudes towards the use of empathy in their
relationships with patients, and need to find ways of delivering nursing care that will maximize the opportunities for nurses to incorporate this necessary construct in their daily work. The high value placed on the primary nursing values of autonomy, accountability, and establishment of one-on-one relationships by these nurses should also be taken into account by administrators, as new configurations of management are incorporated.

Nurse educators must remain aware of the importance of interpersonal relationship skills to practicing nurses, and not reduce the emphasis on establishing caring relationships with clients in favour of increasing education for roles that take the nurse away from the bedside. This study has shown that caring, an empathic attitude, and the establishment of one-on-one relationships are still important to nurses in spite of the negative influences in their working environment.

Important implications for nurse researchers were uncovered by this research. The decision to study trait empathy was appropriate, and yet the instrument chosen to measure this construct created problems, some of which became evident and others that may have remained hidden. The nurses were sensitive to the length and wording of the empathy instrument as well as to the intrusion on their time. Researchers need to remain aware of the current working world of the nurse in order to design studies that will obtain the most meaningful results in the most expedient manner.
Recommendations For Future Research

Nursing continues to identify empathy as an important construct in the development of therapeutic nurse-patient relationships. Further studies are needed to delineate the influences in the world of the practicing nurse which lead to increased levels of trait empathy.

A replication of this study using a different instrument to measure trait empathy, and more definitive examples of the nursing care delivery systems may provide a more accurate picture of the influence of the nursing care delivery system on nurse trait empathy.

The objections expressed by the nurses to the instrument chosen for this study may indicate that completion of this type of instrument is not valued as a means of extracting the true feelings experienced by the nurses. A qualitative study allowing nurses the opportunity to express their feelings about empathy in relationships within the present system may offer a clearer picture of the interaction between the values that guide nursing practice and the restrictions imposed by the environment. By assessing nurses’ interpretations of what empathy is, and how it fits into their practice, including their opinions of how the delivery system supports or undermines the use of empathy, the researcher may get a clearer idea of the inter-relationship between empathy, values and the nursing care delivery system in which the nurse is practicing. A participant - observer method would provide an even richer set of data for this type of study.

As stated previously, nurses are concerned about their ability to continue giving quality care in the present health-care system. Their interpretations of how
empathy fits into their definitions of quality care would be invaluable to nurse empathy researchers.

The beginning investigation of how values affect nursing practice was intriguing, and suggests that further research in this area could be done to extract and clarify the kinds of values that guide nurses in their daily work, and the origins of these values. A study looking at personal values as related to the age of the participant would provide information regarding the influences of changes in nursing education. In addition, it would be interesting to know whether personal nursing values guide the nurse to choose a particular area of practice, and if a congruence between personal values and organizational values leads to increased job satisfaction.

Conclusion

Completing this research has been an unparalleled learning experience, from the initial intuitive hunch that there was a difference in nurses' relationships with patients in the primary nursing care delivery system to the final outcomes of the study. The literature review begged for specificity in defining the area of research. Results showed that there was no difference in nurse trait empathy as measured by a self-report tool in the two delivery systems under study. In addition, the moderately high scores obtained by the nurses in this study tell us only that self-report measures of trait empathy were in this range, but cannot be generalized to assume that nurses have moderately high empathy levels, as has been reported in previous nursing research with similar results. The choice of the instrument to measure trait
empathy seemed to be the best one available for the requirements of this study, however the nurses’ reactions to the instrument were unexpected and provided a great learning opportunity.

Although this study rendered few significant statistical findings related to the hypotheses, it provided a window through which to view the current working world of the nurse. It is important for nurse researchers to remain aware of current situations in the nurse’s working environment, particularly when studying nursing practice. Results will be greatly affected by the sensitivity of the researcher as well as the appropriateness of the research being conducted. In this study, some of the respondents obviously believed that a different focus dealing with work life issues would have been more valuable to them. It became obvious during this research that nurses in practice have many issues that influence their work. Perhaps the strongest message they are trying to convey is that patient outcomes are very important to them, and they feel that in the present environment, these are being compromised.

This research has shown that nurses do care - they care about their relationships with patients, they care about their work, and they care very much about how their work influences patient outcomes. As they continue to struggle against increasingly opposing forces, it is important to recognize and support their position.
Appendix A

NURSING PHILOSOPHY

Hospital A

The philosophy of nursing is based on an ethic of caring that serves as a universal value guiding nursing practice.

We endorse the mission statement, hospital and management philosophies of the and Corporation.

Our practice of nursing is in accordance with the New Brunswick Nurses Act (1985) and is governed by the CNA Code of Ethics and the NANB Standards for Nursing Practice.

We believe in the promotion of a professional image of nursing in the hospital, the community and the profession.

We believe in a multidisciplinary team approach, coordinated through primary nursing. To this end we promote mutual respect, initiative, creativity and effective communication.

We believe patients and family have the right to make informed choices and share the responsibility for maintaining and promoting their own health.

We believe the assurance of quality care is based on support from all services and disciplines within the organization.

In a decentralized nursing organization, we believe nurses must be accountable and responsible for their nursing practice. As a part of the administrative team, nursing management supports nurses in their practice.

We believe in proactive responses to the changing health care system through education, research and the prudent use of available resources.
Appendix B

NURSING PHILOSOPHY

Hospital B

The nursing department of the Hospital believes caring is the spirit of nursing and its fundamental value with the patient as the focus of this care.

Nurses as the primary care givers are committed to ensuring that all patients receive care in a dignified manner which respects their worth, value and beliefs.

As patient advocates, nurses build support for patients, families and peers while working towards an optimal outcome.

Health promotion and prevention is one component of the education nurses provide to patients on the care continuum from birth to death in both the acute and chronic phase.

Education and research are valued by nurses and their participation demonstrates pride and commitment to their profession.
Appendix C

Nursing practice is affected by many influences in the working environment, both individual and organizational. Below you will find a number of statements which may indicate the way in which you routinely practice nursing. Please read these statements carefully and indicate the extent to which you agree or disagree with each one. If you DISAGREE STRONGLY with a statement, circle the number “1” beside the statement. If you AGREE STRONGLY with a statement, circle the number “7” beside the statement. If your attitude or view is somewhere in between these two extremes, circle the number (“2”, “3”, “4”, “5”, “6”) that best describes your agreement or disagreement with the statement.

Please circle the number that best describes the degree to which each of the following statements is reflective of what is important to you as a nurse. Please try to respond to each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree Strongly</th>
<th>Agree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is important to me to have responsibility for all of the nursing care related to my assigned patients.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2. It is important to me to have the freedom to make independent decisions about my assigned patients.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3. It is important to me to be able to develop one-on-one relationships with patients</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4. It is important to me to work where there is an equal division of work among staff.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>5. It is important to me to work efficiently within reasonable time limits.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>6. I like to be assigned one task for all patients (eg. medications).</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

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### Appendix C

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organization in which I work supports nurses who take responsibility for all of the care given to assigned patients.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2. The organization in which I work supports nurses who make independent decisions about patient care.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3. The organization in which I work promotes the establishment of one-on-one relationships with patients</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4. The organization in which I work promotes an equal division of work among staff.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>5. The organization in which I work promotes working efficiently within reasonable time limits.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>6. The organization in which I work promotes the assignment of one task for all patients (e.g., medications).</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D

DEMOGRAPHIC DATA

AGE: _____
SEX: MALE _____ FEMALE _____

YEARS OF EXPERIENCE AS A REGISTERED NURSE:
FULL TIME (TO PRESENT) _______
PREVIOUS (PLEASE SPECIFY) _________________

BASIC NURSING EDUCATION: (if you have both, tick both)
DIPLOMA SCHOOL _____ UNIVERSITY SCHOOL _____

COMMUNICATION SKILLS TRAINING
DID YOU LEARN ABOUT COMMUNICATION SKILLS AS PART OF YOUR
BASIC NURSING EDUCATION?
YES _____ NO _______
DID YOU HAVE AN OPPORTUNITY TO PRACTICE COMMUNICATION
SKILLS AND GET FEEDBACK ON YOUR PERFORMANCE?
YES _____ NO _______
IF SO, DID YOU LEARN ABOUT USING EMPATHY SPECIFICALLY AS A
COMMUNICATION TOOL (i.e. APPRECIATING ANOTHER'S EXPERIENCE
AND FEELINGS AND COMMUNICATING THIS TO THE OTHER PERSON)?
YES _____ NO _______

COMMENTS:
_________________________________________________________________
_________________________________________________________________

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ATTENTION ALL NURSES!

All RN’s who have worked on this unit full-time for at least a year are invited to participate in a study of nurse-patient relationships in different nursing care delivery systems.

Please take and complete one of the questionnaires below. When completed, place in the sealed box located in the nurse’s station.

Thanks so much for your participation.

Trudy Larsen
This notice is to remind you that if you wish to participate in my study of nursing care delivery systems, I would very much appreciate having your questionnaire completed within the next week. Please place the completed forms in the sealed box provided at the nursing station.
ATTENTION NURSES

Apparently there has been some misunderstanding regarding some of the items on the main questionnaire. This is a questionnaire that has been used many times in previous nursing research, and the negative items are worded that way on purpose - not to accuse nurses of this type of behavior, but to allow an opportunity for the respondent to really think about each answer. Sometimes when we are responding to a large number of items which are worded similarly, we tend to answer them all in the same way. I hope that this helps to clear up any misconceptions. I am hoping for a few more completed questionnaires - so I will be leaving them here until next Monday. I really appreciate your input and your participation.

Thanks,

Trudy Larsen.
Dear Fellow Nurse,

I am a student in the Master of Nursing program at Dalhousie University and I am conducting a study to understand how different nursing care delivery systems affect nursing practice. The unit on which you work is being included in this study and I am looking for nurses who are willing to participate. Your decision to participate is completely voluntary and you may refuse or withdraw at any time. There are no risks involved as your name will not appear on any forms and the hospital will not be told whether you have participated.

The questionnaires should take less than one-half hour to complete. The questions ask your opinion about your usual pattern of interacting with patients. Please be assured that there are no right or wrong answers. Rather, I am interested in knowing what you think. Please do not sign the forms as all answers will remain anonymous. Your answers will be pooled with others in groups in order to tabulate results. The information gained from this study can help to increase our knowledge about how nursing practice changes with different delivery system methods. The information gathered for this study will only be used for research and teaching purposes. When the research is complete, a copy of the thesis will be sent to your hospital library so that you will be able to access the results if you are interested. A summary of the results will be posted on your unit when available.

This thesis is being conducted under the direction of Professor M.J. Horrocks at Dalhousie University. She can be reached at 1-902-494-2535 if you have any concerns.

If you choose to participate in this study, please complete the questionnaires within three weeks, place them in the plain envelope provided, seal it and place it in the box marked "Nursing Care Delivery System Study" situated at the nursing station.

Sincerely,

Trudy Larsen R.N. B.N.
June 27, 1996

Unit Manager
(Functional Delivery System Hospital)

Dear ,

Please express my appreciation to the nurses on your unit who participated in my research study. I know how busy nurses are today, and I realize that asking for more of their time is a big request. Input from practicing nurses is important however, in order that we can become aware of the problems they are facing. Nurse researchers are also very interested in patient outcomes as they relate to nursing care.

Thank you again to the nurses on your unit for your participation. A copy of the thesis will be made available to your hospital library when it is completed.

Yours truly,

Trudy Larsen
June 26, 1996

Unit Manager,
(Primary Nursing System Hospital)

Dear [Name],

Please express my appreciation to the nurses on your unit who participated in my research study. I realize that these are hard times in the nursing world - I also work as a casual nurse. I appreciated every bit of feedback that I received from the nurses who participated, and also from the nurses who had reasons for not participating. This is all important information for the future of nursing research and the directions that it should take. Nurses are interested, as they should be, in discovering ways that their day-to-day working lives can be influenced positively. Nurse researchers, like myself, need to be attuned to what nurses want so that our research can be meaningful.

Thank you again to the nurses on your unit for your participation. A copy of the thesis will be made available to your hospital when it is completed.

Yours truly,

Trudy Larsen
Appendix K

1 December 1993

Elaine L. La Monica, Ed.D., J.D.
245 East 63rd Street, Suite #1914
New York, New York 10021

Trudy Larsen, B.N.
33 Scovil Road
Saint John, N.B.
CANADA E2H 1S1

Dear Ms. Larsen:

Please be advised that you have permission to use the exact La Monica Empathy Construct Rating Scale for the research investigation described in your recent letter of 22 November. This permission covers the duplication of no more than 200 copies for this particular investigation only; the exact instrument must be used and may not be changed, adapted, or altered in any way.

A condition for permission is receipt of a copy of the finished manuscript(s) and/or article(s) reporting on your above titled investigation. All duplicated instruments, manuscripts, publications, and works emanating from research using the above titled instrument must contain the following credit:


The La Monica Empathy Construct Rating Scale may not be published or reproduced in any form other than as specified in this letter. The instrument cannot be reproduced in your dissertation. Thank you again for your interest in the ECRS instrument and I would like to wish you the best of luck in your research endeavors.

Most sincerely,

Elaine L. La Monica, Ed.D., J.D.

ELL:e
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