Exploring the concept of empathy in nursing: can it lead to abuse of patient trust?

Empathy is often promoted as being desirable but any new initiative to improve care should be carefully considered to ensure it does not put patients at risk

INTRODUCTION

Welsh universities have announced their intentions to measure and monitor nursing students on their ability to show compassion to their patients (Santry, 2010). Interest in this aspect of nursing practice is influenced by government agendas aimed at improving the image of the NHS.

It is important to understand the terms compassion, sympathy and empathy. These are used interchangeably in nursing literature, resulting in confusion and manipulation of these concepts in the healthcare environment.

The term empathy has its roots in psychology and is considered to be a vital component of the counselling relationship. However, the boundaries of the counselling relationship differ from those of the nurse patient relationship; it is these distinct differences that have implications for patients.

This article discusses the principles of empathy and the vulnerability of nurses to new initiatives that aim to improve nurse patient relations. It examines the risks these relationships pose for patients.

Nurse advocacy, patient empowerment, consent and confidentiality are discussed as examples of potential areas requiring careful consideration.

COMPASSION, SYMPATHY AND EMPATHY

Interest in the role of empathy within the nurse patient relationship has been growing over the past few decades (Yu and Kirk, 2008) and is often considered to be a crucial component of quality care (Reynolds et al, 1999).

Words like compassion, sympathy and empathy are commonly used terms in nursing texts and journal articles. However, there appears to be general confusion about what these terms actually mean (Schantz 2007; von Dietze and Orb, 2000).

Definitions are outlined in Box 1.

Sympathy is the verbal and non-verbal expression of sorrow or dismay (Morse et al, 1992).

ORIGINS OF THE TERM EMPATHY

The term empathy originates from the German word Einfühlung and was first used by Robert Vischer in 1873 to describe the projection of human feeling on to the natural world.

In psychology and counselling literature, it is used to “explain how we discover that other people have selves” (Wispé, 1987). The term was popularised by the psychologist Carl Rogers. His research focused on the relationship between the client and the therapist rather than the process of therapy itself, placing the client at the centre (Rogers, 1951). This work has influenced the concept of patient centred care which emerged from discourses of the “self” in the 1960s.

Counselling literature says that the self

PRACTICE POINTS

I Nurses should carefully examine the background of any new initiative that claims to improve nursing practice, especially those which appeal to a nurse’s self image.

I New initiatives which are influenced by politico-economic drivers and involve the measurement of skills or attitudes may lead to unwanted and possibly unvalidated competency indicators.

I The empathetic understanding of patients by nurses has the potential to put the patient at risk.
concept is heavily influenced during our formative years by the attitudes of others. A negative self-concept is thought to arise from a highly critical environment that distances the individual from their “organismic self”. This causes confusion and, ultimately, results in the individual living out their lives by an external rather than internal focus of evaluation (Rogers, 1951). This means that the individual does what they believe others would want them to do rather than following their own desires.

Within counselling literature, empathy is defined as having the capacity to identify and understand another individual’s emotions and feelings. More specifically, empathy forms part of the “core conditions” along with congruence (being genuine and transparent) and unconditional positive regard (being non-judgemental) (Rogers, 1951).

Rogers asserts that the core conditions are vital for the formation of a relationship where a counselling client can reconnect with their self-concept. Ultimately, this enables the client to become less judgemental of themselves, more congruent and empowered to find their own unique way forward through life’s problems.

Core conditions are considered to be of equal importance as they are all required to allow an individual to reconnect with their “true self” and move forward in their lives in their own individual way. This is in contrast with the portrayal of empathy in nursing literature.

**EMPATHY AND NURSING PRACTICE**

Within nursing literature, empathy appears to be valued as a concept to be used alone rather than within a relationship containing all the core conditions.

Within the nurse patient relationship, empathy is conceptualised as having therapeutic value and, as such, is promoted to nurses as being desirable (McCabe, 2004). Some of the latest initiatives aimed at improving the patient’s experience include teaching nurses to be more empathetic (Yu and Kirk, 2008). Rogers asserts that the core conditions are vital for the formation of a relationship where a counselling client can reconnect with their self-concept. Ultimately, this enables the client to become less judgemental of themselves, more congruent and empowered to find their own unique way forward through life’s problems.

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**BOX 1. DEFINITION OF TERMS**

I Empathy – allows understanding not only of other’s beliefs, values and ideas but also the significance that their situation has for them and their associated feelings (Rogers, 1951).

Within the nurse patient relationship, empathy is defined as: a human trait; a professional state; a communication process; caring; and a special relationship (Yu and Kirk, 2008).

The value of empathy for the nurse patient relationship is thought to allow understanding not only of other individuals’ beliefs, values and ideas but also the significance that their situation has for them and their associated feelings. In short, insight is gained into the mind and thinking of the patient. Schwaber (1981, cited by Olsen, 1991) emphasises this point when he refers to empathy as “a method of observation”, while Yu and Kirk (2008) suggest that empathy can be taught as a skill.

But is an empathetic relationship altruistic? Golis (1995) asserts that empathy is the “hook” into another person’s emotions and that there is often an ulterior motive for wishing to gain this type of insight. Similar concerns are raised by von Dietze and Orb (2000), warning us that nurses do not make judgements in a vacuum and will always be influenced by “particular values and dynamics around patient care”.

It appears the nature of empathy, as conceptualised by the nursing profession, allows the nurse to maintain a professional and intellectual objectivity as there is no commitment to enter into the other person’s suffering, only to understand. This distance, while allowing the nurse to make objective and rational decisions about patient care, also provides a means to gain psychological information about that patient.

Empathy, as initially described by Rogers, reflected a deep desire to understand and enter into the experience of another human being may become in healthcare a method of gaining trust and obtaining information. What happens to information provided by the patient?

In the counselling relationship, the deep empathetic understanding is used to express a desire by the counsellor to fully identify and understand the other person’s experience as if it were their own. Used with the core conditions of congruence and unconditional positive regard and within the boundaries of the counselling relationship (absolute confidentiality between the counsellor and client), the counsellor seeks not to influence the client but to provide them with the conditions that they require to listen to their inner voice.

In nursing, however, it could be argued that there are many conflicting agendas relating to the constraints of the healthcare environment and the nurse patient relationship that make it inadvisable for the nurse to be privy to such information.

Some authors have questioned the value of seeking to develop empathetic nurse patient relationships within busy acute healthcare settings due to the constraints of this environment (Wong, 2004). This suggests there may be inherent problems with the empathetic relationship in this setting.

Despite these concerns, a new discourse about nursing practice has emerged. This includes the following questions: how empathetic are nurses? Can we teach them to be more empathetic? How can we measure empathy?

Before nurses jump on this particular bandwagon and sign up to have their levels of empathy measured, perhaps they need to carefully consider who is investing in this particular discourse and who will gain from it.

**POLITICS OF COMPASSION AND EMPTHATIC CARE**

In the UK, compassion and patient centred care have gained increased prominence, which has led to renewed discussion and debate about what constitutes good nursing care.

The influences on such discussion include government policy, the requirements of statutory nursing regulatory bodies and recent initiatives that promote the “centrality of compassion in nursing” (Cornwell and Goodrich, 2009). While this appears to be innocent enough – perhaps reflecting a desire to improve patient care – closer examination reveals that compassion appears to have become a commodity or a product of the healthcare system (Por, 2008).

Empathy has also become a “tool” which researchers are showing an interest in measuring (Yu and Kirk, 2008). It is not just healthcare providers who are attempting to commercialise compassion and empathy; those receiving healthcare now view themselves as consumers and, rather than passively accepting care provision, are actively questioning the care that they receive (McQueen, 2000).
However, it is worth remembering that the patient is also a commodity of the healthcare market and as such, is subjected to constant surveillance and is constructed in terms of measures such as pain, clinical trajectory, and audit rating (Richman and Mercer, 2004).

This means that notions of both compassion and empathy in nursing care are highly political with a politico-economic agenda rather than an altruistic one.

NEW INITIATIVES, NURSING, POLITICS AND POWER

Many new nursing initiatives originate from evidence-based practice. This means that nurses are continually driving growth and change.

The influence of government priorities on nursing is evident in the response to events at Stafford Hospital (Rose, 2010) and the inquiry into care provided by Mid Staffordshire Trust (Department of Health, 2010). Public opinion and media attention become the main drivers for government policy relating to healthcare, as the government makes an effort to avoid embarrassment reacts to critical reports (Hart, 2004).

This means that politics directly influences nursing practice, with government agendas being influenced by public opinion making headline news. It follows that the responses of nurses are politically significant, yet nurses are often unaware of this power and are portrayed as victims (Hart, 2004).

The problem with new initiatives to measure or monitor compassion or empathy is that both of these concepts are considered to be central to a nurse’s identity. Understanding what influences these new initiatives is important as it can help to identify those with vested interests in their success.

EMPATHETIC UNDERSTANDING – A ‘TASK’?

The professionalisation of nursing has helped to move it from instrumental rationality with its focus on procedures and routines (task orientation).

The focus on tasks is influenced by the medical model and sometimes this is referred to as “old nursing”. “New nursing” focuses on the individuality of the patient, with person-centred care, and has sought to counteract the effects of the medical model, with its associated depersonalisation (Salvage, 1990).

This means that there is an increased emphasis on person-centred care and on the quality of the nurse-patient relationship. Any new initiative designed to improve this relationship – and therefore the patient’s perception of their care – is potentially fraught with danger.

Areas where particular caution is required relate to situations where the patient may be influenced by the nurse or the needs of the wider healthcare environment. These include advocacy, patient empowerment, consent and confidentiality.

The boundaries of confidentiality

Why should an empathetic nurse-patient relationship be a cause for concern? Comparisons between the counsellor-client and nurse-patient relationship are perhaps helpful to identify possible tensions.

Patients trust nurses who are empathetic towards them as they feel that the nurse cares about them (Määttä, 2006). It is important to recognise that there is an imbalance of power in the relationship between the nurse and the patient; therefore, the patient is vulnerable (Sellman, 2007).

The trust that is generated by the empathetic relationship allows the nurse to become privy to information that, in any other situation, the patient may not disclose. This type of relationship fosters the sharing of deeply personal information that can be used in a variety of ways. This does not suggest that nurses deliberately exploit their patients but the environment in which they work makes demands on how this information is used and raises the question: what do we do with personal information?

Patients have different models of understanding the boundaries of confidentiality from nurses and doctors (Jenkins, 2005). This means that we should clarify with our patients whether they wish to have their innermost feelings and personal logic documented or shared with the healthcare team.

We need to carefully consider whether we always gain consent for the sharing of all information that a patient has confided in us and how we document such information. Counsellors rarely document detailed personal information relating to their work with their clients to maintain their clients’ privacy.

Conflicts of interest

Empathy within the counselling relationship involves unconditional positive regard and congruence.

This, essentially, means that the focus is on enabling the individual to become self-directed; this is termed “non-directive counselling” as there is no hidden agenda (Rogers, 1951).

In contrast to nurse training, counsellors undergo a lengthy period of personal development; this enables them to recognise and take ownership of their personal prejudices and ensures that they do not influence the individual’s frame of reference (Sanders, 2002).

The economics and management of the healthcare system changes the perception that nurses and doctors have of their patients.

For example, when healthcare resources are limited, health professionals may perceive patients who take up more resources as being more demanding (Stearns, 1991). This is a good example of the conflicting agendas that are present in the healthcare environment and nurses need to be extremely careful that their relationships with patients are free from prejudice.

This means that the role of nurse as patient advocate is a concern; claims have been made that nurses are still grappling with ethical dilemmas of this role due to conflicts of loyalty between the needs or wishes of the patient and those of the employer (Martin, 1998). Nurses may not be aware of these demands or may feel powerless to do anything about them.

Patient autonomy and empowerment

As the “expert” professional with specialised knowledge, nurses have a considerable influence on their patients.

Some of the ways in which nurses influence their patients is demonstrated by Lawrence et al (2010), who identified that nurses and patients’ families select interventions aimed at “promoting, improving and sustaining behaviour” following stroke.

The authors state that this type of activity increases concordance with lifestyle changes for patients and it illustrates the power that nurses have over patients and their families.

This is a stark reminder of the imbalance of power and paternalistic nature of the healthcare environment. Nurses need to carefully consider how power is used and ensure that patients are not unwittingly placed in a vulnerable position.

### BOX 3. EMPATHY AND NURSING:AREAS OF POTENTIAL CONCERN

- Consent
- Nurse advocacy
- Confidentiality
- Patient empowerment

**Confidentiality**

**Consent**

**Patient advocacy**

**Nurse empowerment**

**Areas where particular caution is required**

- Where the patient may be influenced by the nurse or the needs of the wider healthcare environment.

**The boundaries of confidentiality**

- Why should an empathetic nurse-patient relationship be a cause for concern?

- Comparisons between the counsellor-client and nurse-patient relationship are perhaps helpful to identify possible tensions.

- Patients trust nurses who are empathetic towards them as they feel that the nurse cares about them.
The discourse of "patient empowerment" is a good example of how the best intentions for patients may be influenced by hidden agendas.

Skelton (1994) argues that seeking to empower the patient is motivated by the wishes of the nurse (the expert), while encouraging the patient to think that it was their idea.

The nurse-patient relationship is far from equal and differs vastly from the counselling relationship where the counsellor seeks to help the client become their own expert.

Nurses have a duty of care towards their patients and this means that great care is needed in areas where the nurse may use the trust established by an empathetic relationship to influence a patient.

CONCLUSION

Viewing nursing within the context of the political influences that govern its practice is helpful in gaining an understanding of the constraints and power relations that are omnipresent in the healthcare environment. Power is a central influence in nursing practice and this means that nurses should be encouraged to seek an understanding of the way that it operates in the social context in which they work. This is particularly relevant when considering aspects of patient care like health education, empowerment, advocacy and consent, where patients are vulnerable to external influence.

The portrayal of empathy in nursing literature appears to derive from its portrayal within counselling literature. The concept of empathy is separated from the core conditions of congruence and unconditional positive regard, so is therefore presented as a tool.

High profile new initiatives to improve patient care that also aim to improve relationships with members of the public need to be carefully examined. They are likely to be the product of discourses that appear attractive to the profession's self concept, but have hidden agendas or dynamics that are not apparently obvious; the practice discourse of the empathetic nurse-patient relationship is an illustration of this.

This area perhaps merits further research including that on: nurses' perception of empathy and its value; the way that the empathetic relationship affects a patient's decision making process; and the effects of an empathetic nurse-patient relationship on the patient's self concept.

REFERENCES


Rogers CR (2004) Beyond empathy: expanding the concept of empathy and its value; the way that the empathetic nurse-patient relationship is an illustration of this. Nursing Times; 86: 4, 42-45.


