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UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

COMPASSIONATE CARE: THE PATIENT PERSPECTIVE

by

Lori Burnell

A dissertation presented to the
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requirements for the degree
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Abstract

Professional mandates call for nurses to respond with compassion (e.g., American Nurses Association [ANA] Code of Ethics, International Council of Nurses [ICN]) and countless hospital mission and vision statements prominently display compassion as their fundamental purpose. As a component of healthcare and nursing models, however, defining characteristics and standards are inconsistent. Compassion as a means of establishing a connection on a spiritual level abounds in the literature (Buck, 2006; Grant, 2004; O'Brien, 2008; Schultz et al., 2007) and is documented as a nursing requirement (e.g., ANA, ICN); however, it remains virtually uncharted from the lens of the patient.

Through interpretive existential-phenomenological inquiry, the researcher endeavored to portray the attributes of compassionate care listening to the voice of the patient. In a hospital outpatient infusion clinic, 26 participants elaborated on personal occurrences characterizing one or more essential attribute of compassionate nursing care. Audiotaped interviews and transcripts were analyzed extensively until seven attributes emerged: personal connection, genuine caring, listen-to-me, competent practitioner, family-like, spiritual connotations, and spreading cheer. An eighth attribute, contrary patient experiences, enhanced the understanding of this phenomenon.

This study substantiated patients' yearning for compassionate nursing care. The patients' perspective of compassion reveals a myriad of opportunities for the nursing profession. Possibilities include the identification and evaluation of potential nursing students and new hires through a compassionate care assessment method. Establishing compassion as a core competency and expectation may be accomplished through individualized care plans, the sharing of patient stories, and evaluating performance based on one's ability to promulgate compassionate care into practice. Bridging the gap in nursing education and praxis through qualitative and quantitative research may enrich nursing professional mandates and assist institutions in actualizing their mission statements.

Dedication

An act of compassion transformed you,
Sharing your perspective was indispensable to this journey.
Celebrating every milestone on this academic adventure,
As if it were your own.

This dissertation is dedicated to:

Dr. Donna Agan, cancer survivor, dedicated scholar, and beloved friend.

Acknowledgments

“Let everything that has breath praise the Lord” (Psalm 150:6) for Jesus Christ, the ultimate exemplar of compassion. My career and each blessed experience is a gift from God Almighty. Thank you, Lord, for these invaluable opportunities and for Your unconditional love and divine guidance throughout this journey.

Though my name is the only one to appear on the cover of this dissertation, a great many people have contributed to its production. I owe my gratitude to everyone who made this dissertation possible and because of whom this graduate experience has been one that I will treasure forever.

Heartfelt gratitude and appreciation is extended to my family, in particular my husband and my sister. Jeffrey, you have consistently supported my academic aspirations, oftentimes at the expense of your own ambitions and desires. This accomplishment belongs to both of us. And to my sister, Vicki, thank you for listening, providing perspective, and unending hopefulness; I am indebted. I also wish to acknowledge my parents, Curtis and Eileen Schennum, for their love, support, and life-example of the benefits of a strong work ethic. I am grateful for my precious mother-in-law, June Burnell, who provided encouragement and support through her constant interest in the progress of this academic undertaking.

Special recognition and appreciation go to my esteemed dissertation chair, Dr. Jane Georges, and committee members, Dr. Ann Mayo and Dr. Donna Agan, for their scholarly insights, constant encouragement, and enriching ideas. Beyond research, this

study has allowed me to establish meaningful connections with these phenomenal women and I will cherish that forever.

Sincere gratitude and recognition are given to those patients who willingly and selflessly shared their personal experiences of the compassionate care that they received from their nurses. May their personal perspectives in illustrating genuine compassion touch many hearts and ultimately influence nurses and their practice.

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“She [nurse] knew there was more just by looking at me. And I felt she took the time and the compassion to say to me ‘I’m going to do this.’ I know it wasn’t ordered and found out that it was something that was very necessary. And I was admitted to the hospital. And it was I feel because of her time and her thinking that things were not right.”

Claire

Chapter 1

Introduction

Imagine the setting. As Jesus departed Jericho on His way to Jerusalem, He was surrounded by eager masses yearning to experience His wonder. Jesus, however, was preoccupied knowing the Romans were plotting to capture and crucify Him in the coming week. From the roadside arose a plea from two desperate men whose blindness relegated them to a class of outcasts and beggars. They cried out, “Have mercy on us, O Lord, Son of David!” (Matthew 20:30; New King James Version).

“Shush!” commanded the crowd! Yet in the midst of all the chaos, Jesus heard their frantic voices and, according to Matthew, He became still and inquired, “What do you want Me to do for you?” They said to Him, ‘Lord, that our eyes may be opened.’ So Jesus had compassion and touched their eyes. And immediately their eyes received sight and they followed Him” (Matthew 20:32-34).

Jesus heard their cries and entered into their suffering despite His own heavy heart, and in so doing became the embodiment of compassion. Through the example of His life, many, including nurses, understand genuine compassion and the ability to establish meaningful bonds with others.

Nurses routinely encounter patients who feel as desperate and as helpless as those blind men felt. Though nurses are unable to *restore* sight, they can pause and listen to the patient's voice and respond, as did Jesus, with compassion.

Modern Day Challenge

Two millennia later, cataclysmic events plague our modern lives with frightening rapidity. Human beings are barraged by graphic renditions of tragedy intended to tug at their heartstrings and desperately call for action. The media's increasingly voracious coverage of human suffering through the explicit rehashing of incidents that focus on the anguish, vulnerability, and powerlessness of others further complicates this condition (Höijer, 2004). According to Dill (n.d.), the media's exposure of worldwide suffering has "drastically altered the relationship between sufferers and sympathizers" (p. 5), devaluing the situation. Persistent and repetitive exhibitions of the pain and suffering of others, compounded by one's own personal distress, have resulted in an epidemic of *compassion fatigue* and apathy.

The dire need for compassionate care has reached an unprecedented level unparalleled by any other time in history (Office of the Press Secretary, 2004). The droning display of pain and suffering is further complicated by one's own tragedies, resulting in a widespread call for compassion on a global level. Several examples underpin this need; however, the University of Denver's DU Portfolio Community (2009) described the significance of this critical lack of compassion a commentary on health care policy. "We spend billions of dollars to avoid having to make the everyday life and death decisions that other countries make routinely. Then we turn around and leave over 40 million Americans without health insurance" (para. 11). In a thought-provoking editorial,

Chew, Armstrong, and Van Der Weyden (2003) posited the question, “Is compassion in its death throes two millennia after one man in Jerusalem advocated loving others as oneself?” (p. 1).

Recognizing the magnitude of this challenge, the White House allocated \$188 million to assist Americans in need as well as \$43 million to a Compassionate Capital fund with proposed requests for additional capital and operational funds extending into the future (Office of the Press Secretary, 2004). While then-President Bush formally recognized the benefits of treating the deprived with compassion, very few empirical research studies have considered this need from the patient’s point of view.

Challenge for Nurses

Professional mandates call for nurses to respond with compassion (e.g., American Nurses Association [ANA] Code of Ethics, International Council of Nurses [ICN]) and countless hospital mission and vision statements prominently display compassion as their fundamental purpose. As a component of healthcare and nursing models, however, defining characteristics and standards are inconsistent. Compassion as a means of establishing a connection on a spiritual level abounds in the literature (Buck, 2006; Grant, 2004; O’Brien, 2008; Schultz et al., 2007) and is documented as a nursing requirement (e.g., ANA, ICN); however, it remains virtually uncharted from the lens of the patient.

Compassion has been a topic of research and deliberation in the fields of “special and developmental psychology, evolutionary neurobiology, economics, and sociology” (Schultz et al., 2007, p. 7). The vast array of literature on spirituality in healthcare occasionally referenced compassion; however, its primary context was as a component of holistic care along with consideration for meeting patients’ biological, psychological, and

social needs (Fawcett & Noble, 2004). Research associating nurses' compassion with patients' suffering was notably absent from the variety of studies conducted by the most prominent profession of caregivers.

Statement of the Problem

There was an absence of research describing compassionate care from the patients' perspective, particularly in acute care settings.

Compassion in this proposal encompassed two distinct views:

- Biblical: "a desire to free others from their suffering" (Access-Jesus.com, n.d., para. 2); and
- Secular: "a sympathetic consciousness of others' distress with a desire to alleviate it" (Merriam-Webster, 2009, para. 1). Furthermore, WordNet (2009) defined *caring*, an adjective to compassion, as "feeling and exhibiting concern and empathy for others" (para. 7).

Compassion and caring was explored conjunctively through the voice of patients and subsequently analyzed according to the existential-phenomenological study method.

Nursing research incorporates the phenomenological approach, which "explores the meaning of individuals' lived experience through their own description" (Holloway & Wheeler, 2002, p. 287). Both Husserl and Heidegger developed their own philosophical underpinnings guiding phenomenological discourse. Husserl's approach emphasized descriptive reporting of life experiences while Heidegger considered phenomenology as a hermeneutic or interpretive process (Thomas & Pollio, 2002).

Although several forms of existential-phenomenology exist, this study focused on an interpretative method. While descriptive phenomenology expresses the immediate

“lived-through quality of lived experience,” interpretative phenomenology carries the experience one-step further, analyzing the “meaning *of the expressions* of lived experience” (Van Manen, 1990, p. 25).

Statement of the Purpose

This study endeavored to portray the attributes of compassionate care, described as nursing’s “most precious asset” (Schantz, 2007, p. 48) and essential to establishing meaningful nurse-patient relationships (Davis, 2006; Roach, 2007; Wallis, 2005). Through interpretive existential-phenomenological inquiry, the researcher explored and developed descriptors of compassionate care from the perspective of patients receiving infusion treatment in a hospital outpatient clinic setting by means of dialogical interview sessions and a comprehensive analysis of the themes identified.

Background

Compassion. Schultz and colleagues (2007) claimed key aspects of caregiving experiences had not been adequately described in the literature and, consequently, not valued. The sole purpose of their publication was to encourage researchers to study the concepts of suffering and compassion in the context of caregiving as a means of articulating what comprised “two distinct concepts that pervade everyday life” (p. 5). Their article offered a conceptual model that connected patient suffering with caregiver compassion.

Prevalent characteristics of compassion depicted throughout the general body of knowledge were (a) a dimension of caring, (b) sympathetic consciousness of another’s distress, (c) sensitivity to the pain and brokenness of another, (d) suffering alongside another, (e) a spiritual connection with another person, (f) attempting to comfort or

alleviate suffering, and (g) a demonstration of the *fruit of the Holy Spirit*, the biblical reference to the visible attributes of “love, joy, peace, longsuffering, gentleness, goodness, faith, meekness and temperance” (Galatians 5:22-23). These seven defining characteristics pertain to this research proposal as they embody the heart of compassionate care found in the literature, including the Bible (Roach, 2007; Schantz, 2007; Schultz et al., 2007; Shelly & Miller, 2006).

Healthcare studies featuring the patient’s perspective on the need for compassion were few in number. Most recently, Walker (2009) analyzed nurses’ and patients’ responses with literature findings relative to the attributes, antecedents, consequences, and referents on compassion. Twelve patients participated in interviews conducted over the course of several months. Synthesizing their experiences, Walker defined compassion as:

An innate quality or trait that enables a nurse to discern the need, discomfort, or suffering of a patient without always being told or asked and provides a level of care for him/her that surpasses basic requirements in such a way that the patient feels cared for, valuable, and safe. (p. 204)

The plethora of literature describing relationship-based care and compassion as a mere component of caring models has not clearly defined what actions constitute compassionate care, despite its prominent citation as a principle of conduct guiding professional behaviors (Milton, 2003; Roach, 2007). Indeed, the first provision of the ANA’s (2008) Code of Ethics (i.e., *the Code*) called for nurses to treat every patient with *compassion* and reverence. Accordingly, the Code stipulated, “The nurse, in all relationships, practices with compassion and respect for the inherent dignity, worth and

uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (p. 7).

Compassionate care is more than a professional code or single item inherent in a care delivery model. Actions characterize compassion when a nurse establishes a unique and caring bond with each patient that includes being without judging, listening with sensitivity, and touching one physically as well as spiritually (O’Brien, 2003). Many have described compassion as the epitome of caring in nursing (Davis, 2006; Roach, 2007; Wallis, 2005); however, Schantz (2007) presented a different opinion: “Nursing discourse featuring the profession's altruistic ideals is not only scarce, but lukewarm at best” (p. 48).

Caring. Nursing theorists (Leininger, 1988; Roach, 2007; Watson, 1988) believed caring theories were central to the nursing profession and, as such, represented the primary gauge by which to assess caring behaviors. Shelly and Miller (2006) reminded nurses that, as “mortal human beings,” they must be dedicated to “choosing life in its fullness for [themselves] and those in [their] care” (p. 91). Christian nurses in particular have been commanded to reflect the nature of God as exemplified by the Good Samaritan, who bandaged the wounds of an injured and neglected stranger, transporting him to a local inn to ensure his care needs were addressed (Luke 10:34). A standard theory or definition reflecting this type of caring has not been examined from the patient’s perspective.

Caring is a characteristic frequently cited in nursing models; however, a suitable framework for compassion or compassionate care could not be found. Roach (2007) proposed a model of caring, describing six Cs, offering a diversity of focus (i.e.,

compassion, competence, confidence, conscience, commitment, comportment). While compassion is but one element of Roach's model of caring, these components encapsulated the defined concept of compassionate care. Roach's ultimate example of demonstrating compassion was illustrated in the following: ". . . being compassionate as your Father is compassionate is translated into a call to imitate God's particular way of being with us, God-with-us" (p. 51). Human caring, according to Roach, equated to love. Roach defined *compassionate care* as imitating God by loving others. Together, the words compassionate and caring, through godly love, described the ultimate means of establishing a human-to-human connection.

The challenge to contemporary nursing became increasingly difficult when the element of compassion was added to the concept of caring. In a 2007 article by Schulz et al. outlining important opportunities for research, practice, and policy changes, suffering and compassionate care were described as *imperative constructs* in the context of those who have sustained injury and illness. Additionally absent from the nursing literature were studies on the topic of compassionate care as a response to suffering.

Compassionate care research. Nursing leaders in Scotland acknowledged the importance of compassion by initiating a major research study aimed at returning compassion to nursing practice. As part of a £1 million action research project, Black (2008) studied four patient wards deemed "beacons of good practice" (p. 70) to integrate a more compassionate approach into nursing care and undergraduate curricula. A chronic respiratory patient, frequently hospitalized over the course of the study, reported that nurses and students listened to her more intently and considered her feelings when providing care. Similarly, Perry (2009) recognized actions as paramount in delivering

compassionate care through a descriptive phenomenological study exploring how Canadian nurses conveyed compassion to older patients in long-term facilities. The emergent theme was that “essential ordinary” (p. 17) became an extraordinary means of conveying compassion from the perspective of these nurses. Actions addressing the essential ordinary needs of these elderly patients were twofold: “attending to the little things and keeping the promise to never abandon” (p. 18) patients irrespective of the situation.

From a quantitative perspective, a single, standardized scale for measuring either compassion or compassionate care was not discovered via an electronic literature search. In an attempt to bridge the gap, this researcher formed a quantitative valuation of compassionate care by superimposing the Spiritual Needs Survey (Galek, Flannelly, Vane, & Galek, 2005) and the Caring Behaviors Inventory (CBI-24) tested by Wu, Larrabee, and Putman (2006). A pilot study attempted to ascertain the dialectical relationship between the spiritual needs of patients and caring behaviors of their nurses utilizing these two published survey tools. The collective results of these two surveys were combined to formulate a single instrument. Accordingly, the characteristics of compassionate care were identified from those patients who completed surveys, measuring the elements of spirituality inclusive of compassion and caring behaviors of their nurses to formulate the Compassionate Care Assessment Survey (see Appendix A).

After completing a pilot study, this researcher deemed a quantitative survey tool was incapable of amply representing the constructs of compassionate care and its importance to the patient. To understand actual patient experiences inclusive of their need for compassion and the associated nursing actions that reflect it, one must explore

the essence of compassionate care through *personal life stories* lived in anecdotes, accounts, and incidents. Hence, employing the techniques associated with interpretative existential-phenomenology appeared a more practical and comprehensive approach to understanding the defining features of compassionate care from the patients' vantage point.

Philosophical Foundation

Merleau-Ponty (trans. 2002) characterized phenomenology as the philosophy of essences, inclusive of the embodiment of perception and consciousness.

“Phenomenology is also a philosophy which puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their *facticity*” (p. vii). Phenomenology, investigating who people are and their actual lived experiences, served as the foundational framework for this study.

Existential-phenomenology is a systematic study of the world with intent to capture how individuals immediately experience a certain phenomenon pre-reflectively, before “the experience is classified by science and rational thought” (Thomas & Pollio, 2002, p. 13). This type of a phenomenological approach endeavors to gain a deeper understanding of the meaning of everyday experiences through the lens of those actively involved in them.

Research Questions

The following open-ended questions were employed to facilitate a dialogue with infusion patients anticipated to evoke their experiences with compassionate care. The initial question was general, allowing the participant to explore the experience of compassionate care in an unstructured interview with the investigator:

1. Tell me about an experience where a nurse cared for you in a compassionate way.
What did this *feel* like?
2. What did the experience you just explained mean to you?
3. If you were to instruct a new nurse on compassionate care, what would you tell that nurse?

If these questions fell short in eliciting the detail needed to portray the phenomenon adequately, the investigator was prepared to probe gently for descriptions of compassionate care and its relevance, considering the following:

1. How would you describe compassionate care?
2. What does compassionate nursing care mean to you?
3. Describe an example of compassionate care?
4. How important is compassionate nursing care to you?

Design and Methods

Prior to initiating a study of this nature, the researcher must consider two important questions: “(1) What about this topic was important enough for me to make it the major concern of an investigation? and (2) In what ways and situations have I experienced the phenomenon?” (Thomas & Pollio, 2002, p. 44). The primary rationale for considering these two questions as precursory steps is to heighten awareness of the researcher’s personal perspectives to “minimize biases or distortions” (Pollio, Henley & Thompson, 2006, p. 30) prior to involving patients in the study.

In addition to these important preparatory steps, the following methodology was employed:

- Preceding the interview process, the researcher became well versed on the topic of compassionate care through an extensive review of the literature and by measuring patients' responses to quantitative surveys rating the importance of various published attributes relating to compassionate care.
- Additionally, practice interviews were conducted and tape-recorded between the researcher and colleagues knowledgeable on the topic of compassionate care. This helped to identify and *bracket* any researcher preconceptions (Holloway & Wheeler, 2002). This technique also helped to increase awareness of possible researcher bias in order "to describe human experience on its own terms and not in terms of theoretical principles" (Thomas & Pollio, 2002, p. 13).
- Infusion center patients meeting the inclusion criteria were approached, appropriate consents reviewed, and assurance of confidentiality reinforced.
- Interviews were conducted, audio taped, and transcribed verbatim to capture patients' experiences with compassionate care.
- Explicitation procedures: Patient interviews continued until "the results are integrated into an exhaustive description of the investigated topic" (Holloway & Wheeler, 2002, p. 181), thereby depicting the essence of their lived experiences.
- Analysis involved identifying "examples to reflective understanding," (Van Manen, 1990, p. 87). Included in this examination was reading patient descriptions and stories of compassionate care, extracting elemental components, formulating meanings, and aggregating them into themes until a thorough exploration into the essence of this phenomenon occurred (Holloway & Wheeler, 2002).

- An *interpretive group* provided diverse perspectives for a critical evaluation of the study and generated thematic meanings (Thomas & Pollio, 2002).
- To ensure that the paradigm of compassionate care was captured, the themes must be credible, transferable, dependable, and confirmable (Lincoln & Guba, 1985). This was accomplished by reporting these themes as attributes, via a case study, that thoroughly described interactions and captured characteristics exemplifying a compassionate care relationship between patients and their nurse.
- The case study was shared with nurse focus groups eliciting feedback and agreement, refining the attributes until the essence of compassionate care was captured.

Assumptions

1. The research location, a faith-based hospital in Southern California, would provide a rich environment to uncover the essence of compassionate care.
2. The phenomenological interview process would provide *thick descriptions* of patients' compassionate care experiences (Holloway & Wheeler, 2002).
3. Patients would understand the notion of compassionate care and be able to articulate their experiences.
4. The researcher's desire to set aside personal experiences and biases, practice discipline, and become immersed in the thoughts and meanings being conveyed by each patient would be accomplished.

Limitations

1. Patients might experience difficulty in understanding and articulating the elements of compassionate care.

2. Despite assurances, patients might be reluctant to share their actual experiences for fear of judgment, retaliation, or an unfavorable impact on their present or future care.
3. Research subjects would be limited to infusion patients receiving outpatient treatments in the participating hospital setting.

Significance to Nursing

Compassion, according to Roach (2007), requires immersion into the pain, brokenness, fear, and anguish of another, even when that person is a stranger. If this type of compassionate care was routinely provided, the effect on patients would be identifiable and understood. To bridge the gap in nursing practice and ascertain the dialectical relationship between the theory and experience of compassionate care, quantitative and qualitative research methods must be explored. Shelley and Miller (2006) challenged Christian nurses to engage in physical, psychological, social, and spiritual research to help improve patient care by “using God as a means to a desired outcome” (p. 293). These authors strongly believed that nursing provided a framework for understanding and, as such, nurses were called to care as their service to God.

Studying patients’ well being as it relates to nursing care is desperately needed. Research focused on compassionate care has the potential to affect patients’ holistic needs as well as provide comfort in their suffering and death. Patients’ needs must ultimately direct the future related to health care delivery models, education, and nursing research. According to Schantz (2007), compassionate care is the virtue that facilitates a nurse’s full appreciation of the pain, suffering, and hardships that patients experience.

The significance of understanding this phenomenon is at the very heart of the nursing profession.

Summary

In her book dedicated to nurses' spiritual calling, O'Brien (2001) described compassionate nurses as those who used their own wounds as a source of understanding and strength, enabling them to identify with the wounds of their patients. Utilizing interpretative existential-phenomenology, this researcher aspired to capture the attributes of compassionate care from the lived experiences of patients. Hopeful that once articulated, compassionate care praxis may then be expounded and subsequently embedded into the role of a professional nurse.



“... I have no shame in discussing anything with them [nurses] and they're there to help and I really attribute my longevity to their care and compassion . . .”

Peter

Chapter 2

Review of the Literature

Compassionate Care

The origin of the word compassion lies in the Aramaic *racham*. Its translation dates to biblical times when the word meant, “to love, pity, and be merciful” (Orr, n.d., para. 1). Von Dietze and Orb (2000) noted that “the English version of compassion has been around since the 14th century, a word derived from the Latin *com* (together with) and *pati* (to suffer), literally [meaning] *to suffer with*” (p. 168). Merriam-Webster’s (Compassion, 2009) definition was “a sympathetic consciousness of others’ distress together with a desire to alleviate it” (para. 1). Christian nursing scholars have referred to compassionate care as the nurse’s ministry, focusing on “the whole person, in response to God’s grace toward a sinful world, which aims to foster optimal health (*shalom*) and bring comfort in suffering and death for anyone in need” (Shelly & Miller, 2006, p. 244). Others Christian researchers believed the drive to provide compassionate care was a calling from God (O’Brien, 2001, 2003; Uustal, 2003).

Christianity urges believers to be compassionate toward one another: “Finally, all of you be of one mind, having compassion for one another; love as brothers, be

tenderhearted, be courteous” (1 Peter 3:8). Furthermore, Christians are commanded to extend their love beyond Christian circles, to those who hate them, their enemies (Matthew 5:44).

Global Paradigms for Compassion

Despite theological differences, major world religions have declared compassion as fundamental to their beliefs and customs. One Muslim scholar (Engineer, n.d.) equated compassion to the true spirit of the Islamic faith, asserting that a person must be sensitive to another’s need in order to demonstrate compassion. Representing Buddhism, the 14th Dalai Lama taught that “compassion compels us to reach out to all living beings,” and “true compassion is universal in scope . . . to act altruistically, concerned only for the welfare of others, with no selfish or ulterior motives” (as cited in Gordon, 1998, p. 1). The central concept of *ahimsa*, crucial to the Buddhist and Hindu faiths and principally pertinent to compassion, was translated by Gandhi “as both ‘nonviolence’ and ‘love’” (Federman, 2002, Hinduism and Compassion section, para. 2). Additionally, compassion is mentioned several times in the Hebrew Bible. One illustration described compassion as a “...feeling [that] should mark the conduct of man (1 Sam. xxiii 21); its possession is proof that men are among those deserving recognition as ‘blessed unto [Yahweh]’; and in Zech. vii. 9 it is included among the postulates of brotherly dealings” (Kohler & Hirsch, 2002, para. 3).

The discourse on compassion has extended worldwide and evolved to its present state, where it “frames our thinking - our political, journalistic and everyday thinking about violence and conflicts in the world” (Höijer, 2004, p. 513). Crigger, Brannigan, and Baird (2006) called for nurses to become compassionate professionals as responsible

global citizens by supporting and participating in international organizations that address social injustices related to healthcare.

The need for compassionate care in nursing is universal. Crigger et al. (2006) declared that “nurses as compassionate professionals are called to collaborate with people of all nations to seek a better future for all” (p. 23). They challenged nurses to learn from other organizations and cultures about their differing healthcare beliefs and practices and to incorporate social justice themes into education and service standards – a lofty proposition when the basic compassionate care needs of patients are inconsistently defined and not routinely addressed in hospitals and other healthcare settings throughout the nation. In the words of Schantz (2007), “while compassion is identified as nursing’s most precious asset . . . nursing discourse featuring the profession’s altruistic ideals is not only scarce, but also lukewarm at best” (p. 48).

Patients’ Perspective on Compassion

Medical insurers require a formal survey process for assessing the patient health care experience; however, elements associated with their satisfaction remain elusive. In an analysis of 3.1 million acute-care inpatient surveys spanning more than 2,000 U.S. hospitals (Malott & Ayala, 2010), Press Ganey identified the primary source of patient satisfaction as the provision of information and *compassion*:

Patients want a caring and knowledgeable staff. They desire a skilled nurse who provides not just information but also assurance and comfort. They want members of their care team to act like a team. They want to see the cooperation and communication. And they want to know that all of this is because the staff truly care about the patient as a person. (p. 15)

Hospitals recognize their future viability is rooted in meeting patient needs and that a component of satisfaction encompasses compassionate care. To that end, the word *compassion* appears prominently in numerous hospital mission and vision statements.

Compassionate Nursing Care

“It is easy to give lip service to the importance of compassion as a cornerstone of good nursing care but this is not sufficient” (Perry, 2009, p. 16). In a recent dissertation, Walker (2009) endeavored to uncover the importance of compassion within the context of a nurse-patient relationship by interviewing nurses and patients at a major urban healthcare facility in the United States. Hospitalized elderly patients in this study described compassion as an inherent characteristic of nurses that enabled them to discern patient needs without being prompted, responding in a way that made patients feel cared for, respected, and safe. These findings aligned with the biblical instruction to “keep yourselves in the love of God, looking for the mercy of our Lord Jesus Christ into eternal life. And on some have compassion, making a distinction” (Jude 1:21-22). Biblically, nurses are called to recognize those in need of compassion and to respond accordingly.

Compassion, essential to nursing, has “claimed to underpin the profession in a larger than life scope” (Schantz, 2007, p. 48). To demonstrate compassion best, nurses ought to draw from personal experiences – their own *wounds* – as a source of understanding and a connection to the wounds of others (O’Brien, 2001). The importance of compassionate care is found in nursing models that describe caring and compassion and is emphasized in the principles of conduct guiding professional behaviors (Milton, 2003; Roach, 2007, Watson, 2009). The first provision of the American Nurses Association’s (2008) Code of Ethics for Nurses emphasizes that “The

nurse, in all professional relationships, practices with *compassion* [emphasis added] and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (p. 1).

Compassion: The Spiritual Connection

Whether in academia or clinical practice, Christian or secular settings, nurses have been taught to care for every patient according to a holistic model in which people are viewed as biological, psychological, social, and spiritual beings. Professional and regulatory guidelines require an individualized, holistic plan of care that speaks to the spiritual needs of every patient (International Council of Nurses [ICN], 2006; Joint Commission, 2008).

In a seminal article exploring the meaning of spirituality in relation to nursing care, Goldberg (1998) affirmed the connection between the *psyche* (spirit) and *soma* (body). At one extreme, nurses perceived making a spiritual connection as simply contacting the appropriate religious leaders and requesting they visit a seriously ill or dying patient. Deeper responses included the ability to make a sacred link with the patient through “recognition of soul [or the] essence of being” (p. 840). Those associations were evident when patients identified their nurses as knowing what they needed and conveyed “hope, caring, empathy and intuition” (p. 840). Because nurses were present during a patient’s most vulnerable time, they were ideally positioned to connect with patients through these attributes of compassion.

O’Brien (2003) believed that, for nurses to connect with patients in a compassionate manner, they must “cope with personal furnace times; problems and

concerns ... that must be kept hidden during the carrying out of nursing activities” (p. 122-123). Her reference to furnace times was “a metaphor for God’s holiness” (O’Brien, 2001, p. 121) as elucidated in 1 Peter 1:7, “that the genuineness of your faith, being much more precious than gold that perishes, *though it is tested by fire* [emphasis added], may be found to praise, honor, and glory at the revelation of Jesus Christ.” O’Brien (2003) admonished nurses that personal concerns “must be relegated to the back burner” (p. 123) to ensure that their absolute, heartfelt presence and focus were on their patients’ needs.

Acknowledging the importance of providing genuine spiritual care to patients, Taylor (2005) encouraged nurses to attend to their “own spiritual formation” (p. 25) in order to effectively care for others. Additionally, O’Brien (2008) recognized the individuality of nurses in terms of their ability and comfort to intervene therapeutically in spiritual matters. She suggested the professional alternative of referring patients to pastoral caregivers in these situations. Sister Simone Roach (2007) believed that compassionate care engenders a response. Ostensibly, compassionate nurses recognize self-strengths and limitations, knowing when to seek consultation on behalf of their patients.

Compassion: The Missing Link in Nursing Studies

Taylor and Mamier (2005) asked adult cancer patients and their primary family caregivers to evaluate spiritual care therapeutics using the Spiritual Interests Related to Illness Scale. These researchers concluded that nurses must exhibit sensitivity when providing “spiritual *nurture* in ways that are welcome” (p. 260) to patients as individuals. Greasley, Chiu, and Gartland (2001) conducted a series of focus groups in a mental health setting in which patients and nurses related spiritual care needs with a person’s

true purpose in life. Participants expressed concerns about the entire philosophy of mental health nursing, becoming less personal and more concerned about the technical aspects of nursing care. They identified a need for care that exhibited compassion and kindness, advocating for the emotional well being of patients in a more hopeful environment. Thus, compassion was found to be an essential element for nurses in these spiritual care studies. Notwithstanding the necessity for the provision of compassion by caregivers, these studies neglected to address what *actually* comprised this type of care from its recipients.

Schantz (2007) expressed concern that contemporary nursing literature and research did not clarify how compassion manifested itself in the countless intimate situations where nurses practiced. Questions about fulfilling the spiritual needs of patients and the nurse's role in meeting these needs through compassionate care remained unanswered. Taylor (2005) affirmed that the ultimate reason for nurses to engage in research about spiritual care was to exemplify Christ, who was "beyond the research and statistics . . . Jesus lived on earth and made people matter, and Christ is present in our lives now, we can make people count – have a name" (p. 27).

The Call for Compassionate Care Research

Compassion is more than a single attribute of a care delivery model. According to von Dietze and Orb (2000), it is an individual choice nurses make that ultimately defines successful professional care. Roach (2007) listed compassion as one of six Cs proposed to address the "pitfalls in caring research" (p. 34). "The six Cs - compassion, competence, confidence, conscience, commitment and comportment evolved over time in response to the question, 'what is a nurse doing when he or she is caring?'" (p. 43).

An unfortunate phenomenon of modern life is that some people rarely, if ever, truly experience compassionate care on a personal level. This trend may be, in part, a consequence of events that focus on the anguish, vulnerability, and powerlessness of others (Höijer, 2004). Persistent and repetitive media displays of pain and suffering, compounded by one's own personal tragedies, have resulted in a society where abuse, neglect, willful violation of one's conscience, and chronic suffering are commonplace (Dill, n.d.). Yet, when a patient's life explodes in a storm of disease, the only potential source of true compassion might be the nurse, someone who barely knows the patient. Consequently, there is need for a touch of the divine through the hands and heart of a compassionate nurse.

Nursing research has yet to establish how nurses connect with patients spiritually and with compassion. Only one instrument could be associated to the Christian constructs of compassionate care; the Spiritual Needs Survey (Galek, Flannelly, Vane, & Galek, 2005). While a plethora of instruments measure nurse caring, surveys evaluating the various elements of compassion from a spiritual or even a secular standpoint was notably absent from the nursing literature (Watson, 2009). Research studies designed to explore biblical characteristics of compassion embedded in common nursing interventions may help define how these nurse-patient connections occur.

Application to Practice and Education

To bridge the gap in nursing practice and education and ascertain the dialectical relationship between theory and the experience of compassionate care, quantitative and qualitative research methods must be explored. Shelley and Miller (2006) challenged nurses to engage in physiological, social, and spiritual research to help improve patient

care by “using God as a means to a desired outcome” (p. 293). These authors strongly believed that nursing provided a framework of understanding and, as such, nurses were called to practice as a service to God.

Practice applications of research findings gleaned from compassionate care studies in nursing may include:

- Understanding the important elements of compassionate care from the patients’ perspective, thereby enabling nurses to incorporate these fundamentals into their individual care plans;
- Providing consistent exceptional basic care (e.g., meticulous toileting, pain management, personal hygiene) irrespective of *any* patient’s shortcomings;
- Engaging willingly into a relationship in which the knowledge, intuitions, strengths, and emotions of both the patient and the caregiver are recognized and respected (Lowenstein, 2005).

Implications relative to understanding attributes of a compassionate care nurse for academic purposes are:

- Determining if compassion is an inherent characteristic in nurses or one that could be taught;
- Identifying and evaluating the ability of nurses to provide compassionate care.

Summary

Compassion is more than an emotion, mandate, or characteristic of a care delivery model: It is about a relationship that demands engagement between nurse and patient. Truly, to apply the essential virtue of compassion in practice, nurses must engage in research to understand what it means and how one enters into the patient’s pain,

brokenness, fear, sense of powerlessness, vulnerability, and suffering. Schantz (2007) urged nurses to acknowledge patients' needs and to remove barriers that preclude compassionate human connections.

“And when Jesus went out He saw a great multitude; and He was moved with compassion for them, and He healed their sick” (Matthew 14:14). He is the ultimate spiritual link to compassion and a true example of caring.



On advice to a new nurse

“Put yourself in the patient’s place or imagine if the patient was a family member, whether it be your child or your parent, and how would you want that person to be treated if it were a family member? . . . Just imagine them caring for someone that they really love and I think it would probably help them kind of learn how to be compassionate with a patient, a stranger.”

Sarah

Chapter 3

Methods

To provide compassionate care, a nurse is obliged to empathize with a patient and direct care accordingly. However, to understand actual patient experiences inclusive of their need for compassion, mere observation is not enough; one must delve into what an individual thinks and feels. Hence, the field of phenomenology was the logical methodological approach to identifying the essence of compassionate care from a patient's perspective.

Phenomenon under Investigation

Holloway and Wheeler (2002) affirmed that significant life experiences formulate apposite phenomenological research topics. Hospital stays can be life-altering events, particularly for cancer patients and those with chronic conditions requiring repeated outpatient treatments. Therefore, these patients might be well suited as content experts for this type of philosophical investigation.

The phenomenon under investigation was oncology and other infusion patients' actual experiences with the compassionate care they received from nurses in both hospital and clinic settings. The branch of phenomenology employed to investigate patients'

perceptions of compassionate care was called existentialism (Merleau-Ponty, trans. 2002).

Through interpretative existential-phenomenology, this study aimed to describe the lived experience of receiving compassionate care. As a qualitative research method, existential-phenomenology places emphasis on “(1) respect for people, (whether patients or study participants), considering them as co-researchers and not as ‘subjects’; (2) the use of in-depth interviewing to discover perceptions and feelings; and (3) rigorous interpretation of texts that result from such interviews” (Thomas & Pollio, 2002, p. 4).

Research Aims

1. Describe experiences that illuminate the phenomenon of compassionate care in nursing from the patients’ perspective.
2. Determine the relevance of compassionate care from the voice of the patient.
3. Develop a deeper understanding of the nature or meaning of the patient’s experience relative to compassion and compassionate nursing care.

Procedures

Bracketing preconceptions. The researcher’s preconceptions were bracketed prior to initiating this study. It was the patients’ perceptions of the compassionate care they received from their nurses under exploration, not the opinions of the researcher. “For researchers this means examining their attitudes, beliefs and prejudices literally to bracket these out, and in a sense, remove them from influencing the research (Holloway & Wheeler, 2002, p. 173).

Recruitment. Potential interviewees were enlisted from a sample of convenience. Nurses caring for patients in the outpatient infusion setting identified those

meeting inclusion criteria with compassionate caring experiences to share. For patients expressing a willingness to be interviewed, an appointment was arranged.

Inclusion criteria. The participants selected included patients (a) receiving outpatient infusion therapy, primarily cancer treatments, (b) English-speaking, (c) 18 years of age or older, (d) willing and able to articulate their experiences with compassionate care, and (e) with prior hospitalization experience(s).

Exclusion criteria. This study excluded patients who (a) voiced trepidation about participating, (b) were unable to think or reason clearly for themselves, and (c) were deemed physically, emotionally, or spiritually unstable by the nursing staff.

Ethical considerations. Prior to initiating this study, Institutional Review Board (IRB) approval was obtained according to established hospital and university policies (see Appendices B & C). The purpose, benefits, and risks of participating in the interview process, as well as possible implications this study may have for future patients was thoroughly explained to each subject-patient. Informed consent via the patient's signature on a pre-printed form was obtained after the researcher read aloud the consent statement to communicate the risks and benefits of the study (see Appendix D). Permission to audiotape each session was requested prior to initiating each interview and patients were told notes would be taken throughout the discussion.

The researcher reinforced the position that participation was *voluntary* and neither refusal nor agreement to participate would affect the nursing care rendered. Patients were forewarned of the remote possibility of becoming upset with the content of the discussion, being inconvenienced, or experiencing a breach in confidentiality. They were also told that the researcher would immediately terminate the exchange, according to the

patient's desires. In the event this occurred, the patient was reassured nursing care would not be affected and that the researcher would maintain confidentiality of the information received up to the termination of the interview as well as the patient's request to discontinue the dialogue.

Right to privacy. "Confidentiality in health care generally is recognised as underpinning the patient-practitioner relationship" (Holloway & Wheeler, 2002, p. 54).

To honor the patients' privacy, the following measures were employed:

- A secluded setting for the patient and the researcher was arranged. Subjects undergoing treatment in the outpatient infusion setting were relocated to a private area and interviews were not conducted in the presence of another patient or visitor unless the patient requested their presence.
- An *Interview in Progress* sign was placed on the door or designated interview space to avoid interruptions.
- Collaboration with the health care team members helped to identify optimal interview times to promote patient privacy as well as to avoid interruptions, patient inconvenience, and discomfort.

Data collection. The following interview ritual was employed to encourage consistency when questioning patients and recording their responses:

- Consent, including the use of an audio recording device, was obtained prior to initiating the process (see Appendix D).
- A preprinted interview guide, one per patient, inclusive of a face page, general statements as to the purpose of the interview, recording an informant code (e.g.,

Patient #1), date and time of the session, as well as an assurance of confidentiality was made (see Appendix E).

- Patients were also informed that detailed notes would be made throughout the interaction, that their participation was voluntary, and that they could terminate the interview at any time.
- Interviewing etiquette was strictly enforced throughout (e.g., turning off the recorder if the patient so requested, offering breaks or the appropriate physical comfort measures when the patient appeared tired or when an interruption occurred).
- The interviewer was prepared to offer immediate attention and referral, as appropriate, to a patient who displayed or reported any physical, emotional, or spiritual distress (e.g., expressing fear associated with the wrath of God; verbalizing a conflicted relationship with one's creator) during the interview process.
- Periodically, the interviewer restated the embodiment of the patient's account to ensure accuracy in capturing their voice.
- Demographic information (e.g., birth year, marital status, number of hospitalizations in the last year, religious affiliations, spiritual practices) was gathered at the end of the interview. This aspect of the interview session was not recorded and the timing related to requesting this information assisted the researcher in obtaining closure.
- Upon concluding each interview, session participants received a journal imprinted with the words *compassionate care* along with the researcher's name and contact

information. The journal provided an optional tool for patients to memorialize additional thoughts and the telephone number of the researcher if they wished to share them.

- Respectful *leave taking* occurred (e.g., asking the patient if they needed anything, following up to ensure their request was satisfied).
- A certified transcriber transcribed responses of each interview session verbatim.
- Twenty-six patients meeting the criteria for inclusion were interviewed until obvious patterns became apparent.

It was important for others to be engaged in the initial and subsequent interpretation processes to minimize researcher intuitions and validate all of the obtained information. Themes from these unstructured interviews were discovered through an open dialogue with a nurse focus group wherein “a context for exchange is created leading to an in-depth description of the [patient’s] experience with [compassionate care]” (Thomas & Pollio, 2002, p. 26). A verbatim transcription of the audiotaped interaction occurred within 1 week of each patient-investigator session. Thomas and Pollio (2002) “found that the specific words of the [patient] inevitably are powerful enough in their evocative and experiential meanings to capture the essence of the phenomenon” (p. 46).

Analytic procedures. Phenomenologists endeavor to understand the essence of a phenomenon in its entirety. If this information were immediately coded into categories, it might “fragment ideas contained in the data” (Holloway & Wheeler, 2002, p. 237). Accordingly, this researcher listened to the audiotapes, read, and re-read interview recordings and fieldnotes until words, patterns, and themes emerged and became well

defined. After this aspect of data analysis was completed, interpretative statements were formed and the researcher searched the content for *thick descriptions*, “everything that a reader may need to know in order to understand the findings” (Lincoln & Guba, 1985, p. 125).

Ajjawi and Higgs (2007) described the stages of data analysis designed “to maintain closeness (or faithfulness) to the participants’ constructs, grounding interpretations in the data” (p. 621). Using hermeneutic phenomenology, they investigated the meaning of how experienced practitioners communicated reasoning utilizing the following steps: immersion, understanding, abstraction, synthesis and theme development, illumination and illustration of phenomena, and integration and critique. This study employed a similar, systematic method to interpret the themes into attributes that demonstrated the patient’s experience of compassionate care.

Summary

“As a human being, many a nurse will say that it was compassion for others that inspired her to become a nurse,” (Schantz, 2007, p. 54). To fully appreciate and further expound on the ideals that drew nurses into the profession and to provide a means for nurses to connect with patients genuinely, compassionate care must be defined through research encompassing lived patient experiences. In the words of von Dietze and Orb (2000), “Nurses will always assert their primary responsibility is to those who require care and that one of the ingredients of such care is compassion” (p. 173). Understanding the essence of compassionate care from the viewpoint of its recipients describes the fundamental goal of this qualitative study.



“ . . . I think it’s more than just training it is . . . these people [nurses] are truly compassionate.”

Zack

Chapter 4

Findings

A phenomenological research methodology was employed to discover patients' perceptions of their lived experiences with compassionate care. The participants revealed several facets of compassionate nursing care throughout the study. Drawing from personal occasions, primarily in acute care settings, patients recalled situations, times, and places wherein compassion was encountered through a nurse-patient interaction.

All participants universally understood compassion from a patient's perspective. In preparation for the patient interviews, the researcher anticipated that clarification for the concept of compassionate care concept might be required absent a standard definition. Instead, all patients immediately shared their experiences with compassionate nursing care, demonstrating an understanding of the initial question, *Tell me about an experience when a nurse cared for you in a compassionate way. What did this feel like?*

This chapter will reveal the essence of compassionate nursing care through the personal journeys of 26 patients receiving treatment for cancer or chronic illness in an outpatient hospital setting. Applying Merleau-Ponty's (2002) philosophy on the

phenomenon of perceived lived experiences, seven compassionate care attributes emerged from these dialogical interview sessions. Furthermore, several patients depicted the antithesis of compassionate nursing care. It is anticipated that these thick descriptions will enhance nursing's understanding of the discourse representing compassionate care from the patient's vantage point.

The Setting

Initially, plans included soliciting participants from the outpatient infusion unit at two hospital campuses. After IRB approval was obtained, the researcher discovered that the second location's outpatient infusion clinic census was severely diminished and the interview setting non-conducive to a private interaction, making recruitment at this location problematic. Therefore, all research subjects were enlisted from a single hospital location.

Preparations were made to conduct interviews in a private office adjacent to the outpatient infusion room. This workspace became a high-traffic area when hospital census approached maximum capacity, causing other outpatient services to be displaced into rooms surrounding the infusion clinic. The upsurge in local activity increased the potential for interruptions. Subsequently, interviews were relocated into the nearby secluded employee lactation room. This space offered privacy, a large window with a view, and minimal hallway distractions.

The researcher prepared the setting prior to each session by positioning two comfortable chairs in the middle of the room facing each other with a small over-bed table in between the patient and the researcher. Standard supplies included a digital recorder, clipboard, consent form, interview guide, and writing utensils. The setup was

simple and conducive to a close-knit interview. Preparing the space before interacting with patients facilitated an uneventful transfer from the outpatient infusion clinic.

Description of Participants

The charge nurse working in the infusion center identified possible study participants. Hence, the researcher approached potential subjects nearing the completion of their infusion therapy, explained the purpose of the study, and asked if they would be interested in sharing their experiences with compassionate nursing care. Twenty-six patients were consented and interviewed from November 18, 2010 to January 18, 2011. Each participant was assigned an appropriate pseudonym for ease of discussion. A summary of the participants' demographic information is presented in Table 1. Spiritual and religious practices information was obtained at the end of each interview, the results of which are displayed in Table 2.

Table 1

Demographic Information about Participants (N = 26)

	<i>n</i>	Percent
Gender		
Male	9	34.62%
Female	17	65.38%
Year Born		
Before 1925 (Greatest Generation)	1	3.85%
1925-1942 (Silent Generation)	7	26.92%
1943-1960 (Baby Boomers)	10	38.46%
1961-1981 (Generation X)	6	23.08%
After 1981 (Generation Y)	2	7.69%
Marital Status		
Single	8	30.77%
Committed Relationship	1	3.85%
Married	12	46.15%
Divorced	5	19.23%

All participants reported a minimum of one remote hospitalization experience and several outpatient encounters. Over two-thirds of these patients recounted two or fewer inpatient hospitalizations within the past year. Two patients avowed 10 or more hospitalizations within 12 months. Participants also related their experiences in the emergency department setting.

Table 2

Spiritual and Religious Practices ($n = 26$)

	<i>n</i>	Percent
Religious Affiliation		
Christian – Catholic	7	26.92%
Christian – Protestant	2	7.69%
Christian – Non-denominational	9	34.62%
Other	5	19.23%
None	3	11.54%
Spiritual Practices		
Do Not Pray	6	23.08%
Pray Occasionally	2	7.69%
Pray Weekly	2	7.69%
Pray More Than Weekly	1	3.85%
Pray Daily	6	23.08%
Pray More Than Once a Day	9	34.62%
Attend Spiritual/Religious Services		
Do Not Attend	14	53.85%
Less Than Once a Month	2	7.69%
Monthly	2	7.69%
2-3 Times per Month	1	3.85%
Weekly	6	23.08%
Daily	1	3.85%

Phenomenological Attributes – The Experience of Compassionate Care

Seven prominent attributes emerged from the descriptions of the experience of compassionate nursing care among patients receiving treatment in an outpatient infusion center. Of the 26 patients interviewed, six shared experiences contrary to compassionate care. Two participants presented detailed descriptions wherein nurses and other health care providers rendered the antithesis of compassionate care.

All patient interviews were audio-recorded with salient points notated by the researcher. After each interview, the researcher documented the circumstances surrounding the process and a reflection on the dialogue. Digital recordings were sent via an e-mail attachment to a transcription service and returned in Word-document format. Transcribed files were uploaded into the qualitative software program, NVivo8®, for bracketing into nodes. This served for initial identification of themes that were segmented into four phases of the interview: the actual compassionate care experience, the ideal notion of compassionate care, experiences atypical or devoid of compassion, and the patients sage advice to new nurses on the provision of compassionate care.

After initial NVivo8® coding, project summaries, source summaries, and node summaries provided insight into preliminary themes and impressions. The researcher reviewed the transcripts and coding with a former cancer patient for intersubjectivity in the classification process (Van Manen, 1990). Consequently, dialogue was reassessed, in some cases reassigned, and sparsely coded nodes re-examined and collapsed into appropriate compassionate care attributes.

The researcher then returned to every patient story, anecdote, personal account, and incident with fresh eyes, absent the benefit of the NVivo8® coding nodes, to extract

phrases or statements directly pertaining to the compassionate care phenomenon. Accordingly, 24 experiential categories were formulated by extracting significant statements from patients' descriptions with compassionate nursing care. Through a comprehensive review of coding nodes and interview transcripts, interpretive summaries were further reduced into seven common attributes. To capture the essence of compassionate care more fully, an eighth attribute portraying patient experiences devoid of compassion were included in the analysis of the data.

Of the seven essential attributes characterizing compassionate care, a personal connection linking patients to their nurses was most prevalent throughout the interviews. Subsequently, the remaining characteristics of compassionate care emerged in the following order of frequency: genuine caring, listen-to-me, competent practitioner, family-like, spiritual component, and spreading cheer. Contrary experiences were also integrated into an exhaustive description of compassionate nursing care. The researcher reviewed synonyms from the *Merriam-Webster Online Dictionary and Thesaurus* (n.d.) and the meanings (i.e., definitions) from the *Webster's 9th New Collegiate Dictionary* (1990) for each theme to further understand the context of every phrase, statement, or story thought to contribute to the essence of the compassionate care nursing. In the patients' own narrative below, italics have been added for emphasis when specifically describing these attributes.

Personal connection.

Synonyms. Personal – individual, personalized, separate.

Connection - relation, relationship, association.

Meaning. “. . . Casual or logical relation or sequence . . . contextual relations or associations . . . a relation of personal intimacy . . . coherence, continuity . . .” (p. 278).

The patients’ perspectives.

Abigail: “And if you can do that [listen] with a patient, you can *make a connection* that is going to make you more comfortable and maybe your family more comfortable that you had that kind of care.”

Brittany: “During a panic attack, it was her [nurse] *gentle touch* . . . love and *embrace* that showed me compassion.

“*See in their eyes,*” calmed me and “*changed everything.*”

David: “. . . when a nurse pays *individual attention*, when the nurse *shares* and is *sympathetic*, even small talk, you know? It becomes much more good feeling for us, as a patient to feel this woman [nurse] *knows what I am going to do*, and she is, you know, able to describe everything.

“So . . . going back to your study, compassion is *really paying attention to the person you are talking to*. This is really the issue. In other words you, if you do that to me, I’m going to feel that I am at that point, *the most important person in your time slot*. You know? Be here now, as they say, you know? *Be right at the moment* and treat your patient, call them up, you know, by name. Do the things that make them feel like you’re sympathetic, you know?

“And make sure that you *know what is important*. But the biggest thing is how the *personal interaction* for an hour or so that I am doing this. They are making me feel better than worse.”

Emily: "Asking if I need something. *Feel secure when they [nurses] handle us* every time. Not rushed, they have the time."

Florence: "I guess I would tell her [new nurse] to think about the patient first. Every patient is different so some people need more reassurance. Some people just want to be left alone. They want to take a nap. Some people need a lot of handholding . . . So it takes a lot of *reading of signals* that might be hard to read."

Genna: "They *always ask if you need anything* just let me [the nurse] know. If you need help with going to the bathroom or just the little stuff, they're *just there for you*."

Helen: ". . . *order things you really need*, like I really needed things, like even the doctor didn't order . . . she was compassionate when she came by and *saw how I was* even though, I don't think it was ordered for her to go by, you know?"

Isabella: "And you know, a patient when they're in a situation where they're sick and they're not feeling good, they want to know that someone cares so it is *the little things that the nurse remembers*. You know . . . you have dogs or kids or whatever the case may be, *personalizing your care*."

Joyce: "They took time for you. And they *reached out to satisfy even when it sounded strange*."

Ken: "Well . . . was almost like lifesaving because I was bleeding, you know, and all that. But she [nurse] *made it seem like it wasn't that bad*, you know, and the way she was like don't worry about it. It's going to get better."

Larry: ". . . *anticipate things* that they're [patients] going to need . . ."

Margaret: "And *everything stops and it's you one on one*."

Nathan (Advice to a new nurse): “They need to know what patient needs at what time and *pay attention to the patient*, their conditions. So I mean pay attention to patients so you know if a patient, patient is feeling okay or comfortable or something. But, but observe patients and ask patient questions. That is it.”

Owen: “I’d say a lot of ways just the fact that they were so, they seemed to genuinely empathize with my situation. *Not only did I feel like I was sort of in it with other people, I felt sort of secure . . .*”

“I feel like the, maybe the common factor or the, it’s just I guess I would say vigilance, attention, to just *be really aware and sort of there* so that somebody going through whatever it is that they’re going through doesn’t feel they are being isolated or ignored or that something might go wrong or they need to be worrying.”

Quintessa: “They have a good attitude. They [nurses] *talk to you. Make you feel like a person* and not just someone there for a treatment.

“They greet you by your name. They make you *feel like a human being and not someone with a condition* that if you’re going to be here or not tomorrow.”

Rita: “I’ve been in the hospital several times and most of the nurses or all of the nurses, probably I can say, they’ve always been very compassionate. Even if they’re very busy. But one time I was very, very much in pain and one of the male nurses . . . I can’t remember his name and I wish I did . . . he came in and *helped me . . .* lift me up with this apparatus that *I didn’t feel any pain*. And he was there to *hold my hand*. And he was very, very kind. And I said, ‘Oh, please leave me on this thing for a minute so I don’t hurt more.’ And he did. He said, ‘I’m not supposed to but

I'll leave you for a minute or so,' and he did. So that helped me a lot. A whole lot.

"They [nurses] *call anybody or anything . . . that can help me* to come in quickly.

And they bring in all the resources they can have so they can help me right away."

Sarah (Describing an allergic reaction experience): ". . . immediately stopped everything and basically just took over and did what they could and they worked as a team to *make sure I was taken care of*. How did it feel like, I felt like I was really an important person at the, even though I may not see them, you know on a daily basis it's like *I'm a part of them* [nurses] *now*.

(Advice to a new nurse): ". . . I know there are times where some patients can be very combative and I've noticed, there was one time a patient, like he went to draw blood and he was annoyed and was like 'oh you're here again?' and 'you guys never quit' and I told him 'we don't want to let you go out not feeling better.' *You know 'we're here to help you' and it kind of changed his attitude* and he was okay and he put his arm out for me to draw so I think it is how you communicate with the patient, even though they're giving you a hard time I think it is easier for you [nurses] to talk to them [patients] if you thought of them as someone you do care for."

Thomas (Advice to a new nurse): ". . . *pay attention to the patients problems*, discuss the . . . I think, I think the . . . letting them, letting them find out how they're feeling and maybe make it more comfortable for them."

Uma: "Nurses are *there with me*."

Vicki: “. . . *she [nurse] sat there; pat me on the arm, telling me things are going to be okay. They’re going to make sure. They are going to do the best of their ability. And that meant a lot to me. It gave me a nice warm feeling, a nice warm welcome.*

“Regardless of race, religion, whatever illness they have, they [patients] are a person that in most cases will be scared. And it is our job [nurses] to give them somewhat comfort. Not just by healing them, by giving them medication, but also *being there.*”

Wendy: “. . . just know that *you are going to be a part of that person’s journey*, too, bad or good, and just don’t give up.”

Xena: “. . . they’re [nurses] *able to develop rapport quickly*, at least they did with me, and I felt after the first visit that actually I had known them for awhile. As soon as I came in, they were able to ask a couple of, you know, just easy questions like ‘did you run into any traffic on your way here.’ Just something like that to break the ice. It was not the usual, ‘Hi, my name is Sally, I’m going to be taking care of you today’ . . . staff has been amazing and their openness with not only finding out about you but sharing of themselves.”

(Advice to a new nurse): “. . . first of all *establish a connection* with the patient before she starts a procedure . . . *connecting* . . . communicating with the person, you know, she really shouldn’t go any further, it’s just a, it’s kind of just like a cold procedure . . . I mean, *eye contact, a big smile*, you know, *touching*.

“It isn’t just words.”

Yale (Advice to a new nurse): “. . . *think of yourself in the position of the patient*. How would you feel if you were, if roles were turned and you were the patient? How would you want them to act toward you? What would you want them to do? What would you want them to feel about you? Because not all patients are going to be lovable characters . . .”

Genuine caring.

Synonyms. Genuine - real, true.

Caring – look out for, mind.

Meaning. “To feel trouble or anxiety, to feel interest or concern . . . to give care . . . to be concerned about . . .” (p. 207).

The patients’ perspective.

Abigail: “Well I, I guess it was at night and I had been in the hospital 4 days and my blood pressure kept rising and she [nurse] came in and she sat with me because there was nothing she could really do without contacting the doctor. And she sat there with me when my blood pressure was very high, and, and it was very late at night. And I just felt comfortable that she could take the time to do that and because she had other patients *but she, cared and she stayed with me* until we got the thing under control. And I think it was probably my first experience and that’s, it was after I had been in the hospital four days. So, and seeing yeah, as an inpatient and she, she just took *care* of me . . . you know in the middle of the night, things get kinda distorted so having someone there was very, very good for me.

“And, I think the, the idea that an example of compassionate care, when my husband was in the hospital two years ago . . . he had a heart attack and, and a staph infection and a lot of other things went on. But every afternoon when I would be here the nurse would, different nurses would come and we’d have an ice cream social. Yeah, and so *she’d take care*, she would not eat the ice cream. But she’d sit there; we’d visit, and have a good time. And I thought that was one of the nicest things that happened when he was here.”

Emily: “Nurses really, really *care*.

“Never feel they are bossy, *they are caring*.”

Florence: “Well I think every time I’m here someone does something compassionate.

They ask if I want Lidocaine before they give me my infusion. They’re *very gentle* with the infusing.”

Genna: “Well my first time in the hospital like they took really *care of me* like I never . . .

I was never in the hospital before.

“I just love how they [nurses] are *really nice to you* like *they care*, shows how they really, *really care about you*.”

(Advice to a new nurse): “I would tell them [nurses] . . . I would ask them . . . are they very patient with people? Is this what you love doing? Because this is what you’re going to be doing the rest of your life, *caring for people*, and that’s what you have to do.”

Helen: “Being helpful and *nice* to someone, and *caring* about all their needs and, and oh,

I don’t know just asking them question and well I’m not very good at answering

questions right away because I'm sort of slow, slow input that way. But, but anyway that's about it."

Joyce: "Well I feel compassionate care comes from that particular nurse's heart. It's how you, yourself, would want to be treated if you were in the same circumstances. So I think that's foremost in my mind that you [nurse] consider the individual and you have to respond in a manner which is professional and yet you're *caring for the patient's wants*."

Ken: "It's like, ooh, from day one it's like they [nurses] *take care*, you know, calm down and you know . . ."

Larry: "I haven't really had a lot of need for nurses so. But through here, I mean, *they take care of everything* . . ."

Margaret: "But it's just about *caring about what happens in somebody else's life*. And that's big in my life to care about what happens to people I'm in charge of or any of my family. And I'd rather put others first and I think nurses do that."

Nathan: "And yeah, when I got nausea she just brought me some medications. And one time when, also when, I missed lunch, they would order for me. That day I was sleeping so they didn't give me lunch order at first but when I wake up they, they . . . *do things very carefully* I mean, yeah, they, actually the nurses here are so great, they're great. They are greatness. And maybe some other question or example is oh, for the first time I, I was diagnosed with lymphoma. And I did the first chemo. And actually at that time I did not feel well . . . psychologically and the physical. And after I'd done this, one of the nurses pointed out the sunset for

me, and takes me to the glasses there and watches the sunset. Actually that kind of thing makes me feel warm and pretty good ...”

Owen: “Well, I guess, first of all I’ve noticed that every time I come in, honestly I feel like I ‘m greeted with quite a bit of compassion, I’d say in particular the first time I came in for my infusion of chemo, I was really nervous about it, I heard about all the side effects and things that could go wrong and I was clearly very anxious about the whole experience. And I found that the nurses were, *helped me* through the process and administering the chemo were very understanding and very attentive and they were very, what’s the word, I don’t know, they were very comforting. They *eased a lot of my concerns* and they were just, they were there and very vigilant the entire time. I’m thankful for that. It was a very stressful first day.”

Peter: “I had some very good nurses, some very good nurses over the years and many of us even though I come back to the hospital frequently, we’ve become good friends. And again, I have no shame in discussing anything with them and they’re there to help and I really *attribute my longevity to their care* and compassion and that’s the truth. I’m not just saying that.”

Quintessa: “And they [nurses] *make sure you’re fed ...give you hugs.*

“The people in the infusion room have really *spoiled me.*”

Rita: “Everybody . . . I have been in the hospital more than ten times, if not more, and everybody’s been *extremely caring.* They’re sweet. They’re compassionate. They’re always *willing to help me.*”

Sarah: "I'm not just a patient. I'm someone that I guess is important, that *people really do care* and want to help. And it kind of helped me with how I'm feeling and my esteem kind of boosted up more."

Thomas: "Oh, they come in a lot and just ask, just ask how you're feeling. More concerned, they are *concerned about how you feel* and it makes you feel good."

Uma: "Nurses are *extreme caring*.

"Throughout my experience many nurses *went the extra mile*."

Vicki: "Well it took most of the fear away. There is obviously going to be some fear, but it meant a lot to me. It got to the point where I kind of look forward to coming here and it also inspired me on doing something I never thought I would've considered before. I did love helping people but never really thought about the medical industry. And see how they [nurses] *care for people*, and some people here unfortunately are never going to be finished with this. I want to one day be able to help people like that, too, be inspired."

Wendy: "Well, this is kind of embarrassing but I'm going to say it. When I was here for my surgery, my surgery, I couldn't – I went to the bathroom a lot and I'd go in the bed, and these nurses were so good cleaning me up and stuff. It was amazing how it doesn't faze them. They were just *always there to take care of you* and keep you clean. They were just – I can't put into words. Instead of sitting there on your own. You know they were wonderful.

"I can't think of one person that in all my experiences since February that I could say well that person - that should be in this business, this has been the most - it's

helped me go through by being around people that are so *loving and caring*. It makes my journey easier.

“You have to have some *compassion and caring* to make your journey. I couldn’t get through without any of this.”

Yale: “. . . it’s important that you have *people that really care about you* and they [nurses] do. They *legitimately care* for their patients.” “Sometimes all I say, I start to utter a statement, a request for something and they jump running up to see how quickly they can get me.

“I look forward to the contact with people *that really care about me*. It’s extremely important.”

Zack: “Well since I’ve been here it’s all been very compassionate. When I had to spend longer and longer amounts of time I’m convinced that it’s more than just training and . . . people here *honesty care*, and they go the extra mile for me, you know? And I try to be polite and not such a pain in the tuckus, but I have seen them go out of their way to make me feel good.

“And I found here, I don’t know if it’s just this hospital or all of California – that everybody’s been - they’re sincere. *They really seem to care.*”

Listen to Me.

Synonyms. Attend, heed, mind.

Meaning. “Hear; to pay attention to sound . . . to hear something with thoughtful attention; give consideration” (p. 697).

The patients' perspective.

Abigail (Advice to a new nurse): "Well, well, compassionate care to me is care that is all encompassing. It's not, you know, just say, come in and say how you are, to *really listen to what you say.*

"You just have to *learn to listen to what the patient is saying to you* and then help, you know, help assure them that they are able to take care of you."

Claire: "And I think that that, to me it's important that you do have that communication with the nurse or whoever's going to treat you at that particular time. And so I guess *being able to talk and her understand* that there was more than just me . . . feeling well. So I guess I'm openly communicating with someone."

Helen (Advice to a new nurse): "I would tell them oh, to know what, what they need and what they want. And to *listen to them* and try to get what they need, what they want."

Joyce: "It felt as if she [nurse] considered me an individual and no matter what I had in mind she *listened to me* and tried to take care of whatever my problem was.

"They [nurses] would *at least listen to you* and consider you to be an individual probably with your own set of complaints or . . . or requests should I say."

"Well it . . . it made me feel very good *when somebody listened to me and could understand* that what I was saying had a concern, whether it was about a complaint or something that was bothering me, whether it was pain or discomfort. They seemed to try to make me feel better."

Margaret (Advice to a new nurse): ". . . I think that's what I appreciate the most is that nurses look at you and *listen to you and understand.* And I think that is a great

thing for the nurses as opposed to the doctors who just don't have the luxury to be able to do that."

Peter: "*Listen to everything the patient says*, no matter how insignificant or small you think it is. To the patient that could be something monumental and it needs to be addressed like that.

"I was put in hospice in 1995 and for someone to *listen to me* and make me feel as though they're with me, they're with me within my body and know that I know my body better than anybody, for them to *listen to me* means the world. It really does."

Quintessa (Advice to new nurse): "...*listen to the patient.*" "So just be there as a *listener.*"

Rita (Advice to new nurse): "*To listen to the patient.* Observe them. Check on them.

Check on them when you feel needed like, if they are frightened; check on them a lot more that you normally would. If they feel as if everything's under control and they don't need extra attention. But if somebody is frightened, doesn't know what's going on, *just listening helps the patient more than they'll ever realize.* So *just be there as a listener.* They're not asking you for an answer or solution. Just let them know you're there in case anything happens."

Vicki: "Sometimes the best way to do it [be there] could be to *just listen.*"

Wendy (Advice to new nurse): "*Listen. Listen* to your patient. Read bet-, you can hear . . . *read between the lines.* They might have something but it's something else they may be saying to you. You know *listen* to your patient."

Zack (Advice to a new nurse): “Oh uh . . . smile a lot and *listen*. The *listening is very important*. You would not be a nurse I don’t think if you weren’t really outgoing. So uh – *be sure to listen*. Don’t be totally outgoing. Be receptive too.”

Competent Practitioner.

Synonyms. Competent – qualified, able, suitable, capable, fit.

Practitioner – interpreter, guru.

Meaning. Competent – “Having requisite or adequate ability or qualities . . . proper or rightly pertinent; legally qualified or adequate” (p. 268).

Practitioner – “One who practices a profession” (p. 923).

The patients’ perspective.

Claire: “Okay, well, I was . . . I had had a treatment two weeks prior and was really feeling down and came in and she [nurse] actually, on her own ordered a CBC and found out that my counts were so low and my platelets were so low that she immediately called my doctor. And I really felt that this person or this nurse took the time to look at me and not just assume that I was there to get an infusion of saline and then walk me out the door and say I was fine. And that wasn’t the case. She [nurse] *knew there was more just by looking at me*. And I felt she took the time and the compassion to say to me “I’m going to do this.” I know it wasn’t ordered and found out that it was something that was very necessary. And I was admitted to the hospital. And it was I feel because of her time and her *thinking that things were not right*. So to me was something that I felt very, very close to a person. And I will always feel close to a person who works in the infusion room because of this.”

David: “So she knows your situation . . . *they* [nurses] *know what they’re doing.*”

Florence (Advice to a new nurse): “Oh and one other thing I would think of is . . . is an attitude of confidence. You want to feel like you . . . your nurse *knows what she’s doing.*”

Larry: “I appreciate the nurse who *knows how* to take blood without poking me twenty times . . .”

Margaret: “They [nurses] just *look at you and know* what is going on . . .

“I do not feel that way about some of the doctors, however, the nursing staff at the hospitals as well, is *so competent.*”

Owen: “I felt sort of secure in, they [nurses] almost came off as *qualified and very competent* in that way. I feel like when professionals demonstrate sort of something outside the black . . . description of their job, I am comforted by that in some way.”

Peter: “. . . acted as though everything was ordinary. Everything was fine. You, know, they’re doing what you think would be rather embarrassing but they are *doing it with confidence* and they are giving you assurance and they *act like it is just a walk in the park.* It’s all right. That is what we’re here for. And it made me feel comfortable and after awhile the humiliation and shame went away. I just felt very comfortable and I thought that was admirable on their part.”

Quintessa: “And they just are *on top of everything.* They know their jobs. They *know how* to handle . . . I’m speaking of myself, since I have a power port, they *know what is required* to take care of or maintain a power port. And I’m really

impressed with the way I'm treated with them. When I'm on chemo, it takes a couple of hours. And I'm just *impressed because of their standard procedures.*"

Yale: "Well, you know the nurse is – she's given a lot of responsibility. She has to be professional. She [nurse] *has to be ready to assist people in some of the worst possible situations* and frankly I do not envy them, I admire them but I do not envy their job. I saw what it was like in World War II, I was in the service in Europe and nurses there were put in the ugliest of situations and they were fantastic."

Family-like.

Synonyms. Blood, kin, people, tribe.

Meaning. "A group of individuals living under one roof and usu. under one head: household; a people or group of peoples regarded as deriving from a common stock . . . a group of people united by certain convictions or a common affiliation: fellowship" (p. 448).

The patients' perspective.

Abigail: "Well, it meant a lot because my family wasn't nearby and, and I, of course you always want your family, but I felt like it was more like *having family with you*, you know, here, under that condition that night. So, I guess that was the comforting part of it."

Brittany (Advice to a new nurse): "Lead with your heart and *treat patients like you are their mom or dad.*"

Genna: "*I wanted my family, my sisters with me. But they were really nice and very helpful.*"

“I felt like I was *being loved, besides my family*, I was like, oh wow, someone cared for me, too like I never knew that so I was . . .”

Isabella: “I think it goes back to the first time I came to this hospital, which was 11 years ago. And I was 18 years old and I was very sick. And nobody knew what was wrong with me. And I felt like for the year prior to when I moved down to San Diego, nobody believed what I was saying. And I just remember I was on the oncology floor of this hospital. And they were just so very nice to me and they were you know comforting. And I’m a huggy person and so like *they made me feel like home, while I waited for my mom* to fly down here. And you know give my hugs and make sure I was okay, and you know just really you know having a smile on their face and not showing worry.”

Nathan: “. . . I mean, oh, I think besides the medical part, I think, I think, they *treat me so good, so I mean like my family*, how to say that I don’t have much to ask for actually. They did everything. They came and, and so thoughtful and . . .” (voice too soft to record).

Rita: “They know you by name right away and they *treat you like family*.”

Sarah (Advice to a new nurse): “Put yourself in the patient’s place or imagine if the patient was a *family member, whether it be your child or your parent*, and how would you want that person to be treated if it were a *family member*? . . . just imagine them caring for *someone that they really love* and I think it would probably help them kind of learn how to be compassionate with a patient, a stranger.”

Uma: “Compassion means a warm *family atmosphere* - not afraid”

(Advice to a new nurse): “Treat the patient like the *closest family member*. Like your own family . . . family support.”

Wendy: “It’s - because really I’m fighting it alone. My family is not here. And I’ve got friends here, but both my sisters are out of state. So when I come here I always *feel like family* now, you know. And they are wonderful people.”

Spiritual Component.

Synonyms. Nonphysical, ethereal, formless.

Meaning. “Affecting the spirit . . . relating to sacred matters . . . related or joined in spirit” (p. 1137).

The patients’ perspective.

Helen: “Let’s see. Well the nurses here have been very compassionate so I would say . . . it’s because it’s also *Catholic*. Because I’m Catholic and I like the way people come around and *they pray with you*, or give you communion once in a while, so it’s really nice.”

Ken: “Oh most of the time, I . . . most of these *nurses to me are angels* . . .”

Peter: “It makes me feel very good. It makes me feel comfortable as I said, but it makes me personally feel as though I’m going to be okay, okay, because a lot of what I’ve experienced, although it may seem like it’s 100% physical, there’s a mental component to it and a *spiritual component* to it and for me, if those two aspects of my health concerns are not matched or addressed in some manner, the rest of my healing process will not take place.”

Wendy: “I couldn’t get through without any of this. You know what I mean? I couldn’t do it alone . . . And I know what I have as far as stage 4 and all this, but *I have so*

much faith in God. My nurses - it helps me get through my journey. Nobody knows what tomorrow will bring, but as long as you have *someone to help and guide you*, it's a wonderful feeling. That's someone that cares. When I first got – my doctor told me what I had, this surgeon, most people would flip out, cry, scream, whatever. You know what? I told everybody, I'm not ashamed to say it – a peace came over me from my head to my toe the moment he said, 'you have stage 4 cancer' and I said, "Okay we'll deal with it.' And I've never – I'm not in denial. I haven't sat home and cried or gotten depressed, but something inside of me, I have a lot of – I just can't describe it. I know it is going to be okay. It is a wonderful feeling. And that's all I can say, you know. It's – and that's not denial either. I just can't fit it into words, the strength I feel inside of me."

Xena: "Well the reassurance factor. I notice these nurses, you know, they're always telling people, you know, 'you're going to be okay.' And there's a lot of patient's in the area that I'm in that I, you know think are very seriously ill and they need that, you know, that *feeling of reassurance and hope* coming from the staff, you know when they come into a medical procedure."

Yale: "We called them angels of mercy and that's exactly what they were. It's coincidence that . . . and *I look at these girls* [nurses] *as angels of mercy*, but I've always had an admiration for nurses. They're very giving and I admire what they do."

Zack: "And at first I thought *because it's a Christian or Catholic* hospital that it's the training they get. But I think it's more than just training it is . . . *these people* [nurses] *are truly compassionate*."

Spreading Cheer.

Synonyms. Joviality, mirth, merriment, gaiety, hilarity.

Meaning. “Lightness of mind or heart: spirit . . . hospitable entertainment: welcome . . . something that gladdens . . . a shout of applause or encouragement” (p. 230).

The patients’ perspective.

David: “You’re not feeling fantastic and you whatever, so when you have a nurse that is cheery, that is *spreading that cheer* that has the good attitude, and greets you and looks at you in the eyeball, and, and personable, you know?

“One of your team you know, one of the hospital people, nurses probably, she had the blue stuff on, so cheery, she said hi to everybody. She said good morning to everybody. She came to the elevator, pushed the buttons for everybody. You know? And sort of cheery, *spread the cheer*. By the time I got to the ninth floor, she got on the eighth, I said, ‘Have a great day. You’re spreading good cheer keep it up.’ She was in heaven, when she heard that. So it is important in a place of healing, to do that.”

Emily: “Compassionate nurses are always in *good spirits*.”

Florence: “And you know your mind always wants to think the worst. And I just remember you know they [nurses] *made light of it*. Something you know, they went to put my IV in and it actually ended up shooting blood everywhere. And *they were just making fun of it*. And they’re just, you know, they had a *good sense of humor* about everything. And so, I think a *positive attitude just made everything a lot better*.”

Ken (Advice to a new nurse): “Well, to me now you’re saying talk about compassionate care seems like it’s more than just medical, what you learn in the books like these ladies out here [nurses] *make you laugh*. You know they’ll do something more than just treatment, you know. They’ll give . . . get a little personal. It seems like everyone’s got a little personal thing, you know *to make you laugh*. This one makes you laugh. This one . . . they all add their own little thing to the medicine. It’s like they’re own medicine, you know. It seems like every one of them got their own medicine for you. And that helps you a lot to, you know.”

Wendy: “They are very special people [nurses] to me. They show a lot of love and care, and they *laugh and make you laugh* and talk to you about anything. They’re very special to me. And *you know it’s funny*.”

Contrary to compassionate care

Synonyms. Diametric, opposite, contradictory, polar, antithetical.

Meaning. “Being so different as to be at opposite extremes . . . not being in conformity with what is usual or expected . . . unfavorable” (p. 285).

The patients’ perspective.

David: “So I feel that these nurses do exhibit a lot of compassion. That is different from my experience when I had an operation, it’s different you know? Again as you mentioned after an operation and rehab and, hospital is not a good place to stay, to rest you know? It’s just too much you know? The noise and this and people [nurses] *know you are drugged so they sort of treat you like an idiot*. And that’s not a good experience.

“So I come in 2 days ago, to this hospital, I go to the lab on the second floor, and after I *wait so long*, she says let me check. I said 929 is the infusion center, go up here. They, they [*nurses*] . . . gave me the idea that if I come in early, she calls and does all this and that. And then comes out, *sorry can't do nothing; you'll have to call your doctor*. Why would I have to call my doctor? ‘He has to give us an order.’ But I do this every month. And every month it’s like no big deal it’s just the same thing. No, no, no, no. Of course I wasted the trip, and they track him down. The nurse says, ‘oh we’ll have to find him. We’ll page him, we’ll do this, it’s a blood thing for a treatment infusion. It is no issue; it’s the same procedure.’ No, so anyway I left . . . I had other things to do, and I didn’t have the time. But I was thinking how efficient would it be if they took my, my blood and saved the insurance and Medicare and all this and did it right?”

Florence: “But she [*nurse*] *put the needle in the arm wrong, ended up with a bruise* that went all the way around my arm. It was like this all the way around my arm and it scared me because I thought, ‘do these folks really know what they’re doing here?’ But it’s never happened again. So, I think it was just one of those odd accidents but it was my very first time.”

Helen: “And be careful *you don't overemphasize things* because they [*patients*] hear the same thing over and over again from everyone that comes in.

“*Everybody was asking me the same question* and that was the only question they asked, so it wasn’t very compassionate.”

Ken: “They’re [*male nurses*] the ones that’s, you know, *they're rougher* than, you know? But the female nurses it’s like you never have any problem.”

Quintessa: “. . . I take Ativan on a regular basis. I was . . . I went to the doctor’s office.

She says, “you’re going to the hospital.’ So I just . . . gave them a list of the medications that I take. And vitamins, forget it, you know but it was a medication. And Cymbalta and Ativan were on there. I was given Cymbalta but not the Antivan. And when you have a blood infection and a bladder infection and no immune system, you’re not thinking very clearly. And a couple of times my body would start to jerk. It would start in my arm and then my whole body was jerking, I was in a trance, I could see the clock. I couldn’t speak. And the nurse says, ‘is something wrong?’ Well, here my whole body is just twitching and jerking away; I cannot talk. And her partner asked me, ‘are you finished with your dinner?’ I was so upset about the incident and scared because I didn’t know what was going on. Now, I have been on Antivan for seven years. And apparently you cannot go cold turkey. And they *didn’t bother to read my medications*. So I was very upset with that incident. And then the next day the nurse came in and I told her what had happened and she immediately checked and she says, well, are they giving you Antivan? And I say, ‘No, I’m getting off of Cymbalta.’ And she said, ‘we are starting you immediately, like, now on your Antivan to get you back on your schedule. So I told her my schedule . . . She immediately got me stated on the Ativan that I take on a regular basis and it helps me sleep at night.

“*No one came into my room*. And that’s what really scared me. What if I was having a heart attack? I would have been dead.”

Rita: “And they are very sweet. The only exception that I had was in the emergency room, but I understand that *they were very busy and that sometimes they do not have enough time.*”

Validation of Attributes with Nursing Staff

After all patient interviews were completed and attributes identified, the researcher returned to the outpatient infusion center and met with the staff nurses charged with providing care to these patients. These expert nurses validated that the primary attributes ascribed by their patients encapsulated their own personal aspirations of providing compassionate nursing care.

Summary

Patients receiving infusion treatments in an outpatient center freely shared a myriad of lived compassionate care experiences with their nurses. Every one of the patients interviewed elaborated on personal occurrences characterizing one or more essential attribute derived from a meticulous review of the recorded transcripts. Most of the patients interviewed described three or more individual experiences wherein they received compassionate care from their nurses.

While seven essential and one contrary attributes emerged from the patients' experiences, no single attribute completely captured the essence of compassionate nursing care on its own merit. Experiences portraying a personal connection between a patient and his or her nurse were those most frequently conveyed in the recorded narratives. A comprehensive analysis of this finding along with an extensive description of the various patient interactions and the other compassionate care attributes will be presented in the succeeding chapter.



“ . . . Compassion is found when you have a heart for the Lord.”

Ken

Chapter 5

Discussion of Findings

Compassion and caring are noteworthy characteristics of the professional nurse as emphasized in nursing discourse. Certainly, codes of conduct accentuate nurses' accountability for the provision of this type of care (e.g., ANA Code of Ethics, ICN). Hospitals' mission and vision statements espouse compassion as their *raison d'être* and present-day patient surveys incorporate probes into the delivery of compassionate care. In the near future, hospital reimbursement for care rendered will be weighted according to patient satisfaction scores in addition to specific clinical outcomes (Clark, 2011). Analyzing 3.1 million surveys rating patient satisfaction, Press Ganey discovered patients from all walks of life desire "caregivers who provide information and compassion" (Malott & Ayala, 2010, p. 12).

The individual physical, emotional, and spiritual experiences of 26 patients receiving treatment in an outpatient infusion center were recorded during interview sessions designed to capture the essence of compassionate care. Personal connection, genuine caring, listen-to-me, competent practitioner, family-like, spiritual connotations, and spreading cheer were the attributes that emerged out of these interactive sessions

integral to a rich and comprehensive portrayal of the compassionate care phenomenon. In addition to these attributes, thick descriptions of the research also provided “a sense of the emotions, thoughts and perceptions that research participants [patients] experience” (Holloway & Wheeler, 2002, p. 140).

The voice of patients resonates throughout this final chapter, endeavoring to attain the essence of compassionate care. Major findings related to the literature and the seven essential attributes that comprise compassionate care are presented along with contrary patient experiences to enhance the understanding of this phenomenon. Strengths and limitations evolving out of this study as well as future implications for nursing praxis are also considered herein.

Experiences Illuminating the Phenomenon of Compassionate Care

Personal connection. A personal connection between a patient and a nurse was the prevailing theme emerging from all of the recorded transcripts and field notes. The majority of those interviewed articulated one or more experiences wherein an individual connection was established between a patient and their nurse, oft times within a short period. A deeper analysis into comments indicative of a personal connection revealed three different types of connections: (a) general statements describing a connection or responses wherein the patient actually mentioned the word connection, (b) those of a physical nature, and (c) bonds resulting from the nurse’s intuition.

Comments depicting a general compassionate connection referenced the nurse’s ability to “establish a connection,” “develop rapport rapidly,” or “see how I [the patient] was.” Several patients linked compassion to physical touch or contact: “Her [nurse] gentle touch, love, and embrace,” “there to hold my [the patient’s] hand,” “sat there,

patted me [the patient] on the arm” and provided “eye contact, a big smile and touching.” Other patients associated compassion to the nurse’s physical presence, “being there,” and “telling me things are going to be okay. They’re going to make sure.” A few patients believed compassionate nurses were those who made a connection by responding to their physical needs (e.g., pain control), or ordering the supplies that a patient deemed necessary, “order things you really need,” “helped me; I did not feel any pain” and “make sure that I am taken care of.” Lastly, commentary denoting intuition spoke to the nurse’s capacity for “knowing what was important,” “reading of signals,” “anticipate things,” and “genuinely empathized with my [the patient’s] situation.”

Research addressing the need for a personal connection in the context of compassionate nursing care was extremely limited. In a single study, Perry (2009) interviewed and observed seven nurses employed in a long-term care facility. The primary aim of her research was to discover the means by which these nurses sensed patient suffering and ways to alleviate it. From those interviews and reflections, she declared “Nurses are known for their compassion and this view connects them to patients in an essential and profound way” (p. 15).

Genuine caring. Most patients mentioned the word *caring* as essential to compassionate care in their stories, insights, and responses to the researcher’s inquiries. Indeed, the public as well as nurses have traditionally viewed caring as foundational to the nursing profession. According to Watson (1988), a renowned caring theorist, “during the past decade, the concepts of care and caring have gained greater awareness and emphasis in nursing literature and research (Leininger, 1980, 1984; Benner, 1984, 1988; Ray, 1987; Watson, 1979, 1985, in press)” (p. 175).

Several patients also mentioned the actual word *care* or *caring* in their thick descriptions of compassionate nurses. The following incorporates a few exemplars from the voices of those patents:

Abigail: “. . . And I just felt comfortable that she could take the time to do that and because she had other patients but she, *cared* and she stayed with me until we got the thing under control.”

Helen: (Compassionate nursing means) “being helpful and nice to someone, and *caring* about all of their needs and . . . just asking them questions and well I’m not very good at answering questions right away because I’m . . . slow . . .”

Ken: “. . . from day one it’s like they [nurses] take *care*, you know, calm [the patient] down . . .”

Peter: “. . . And again, I have no shame in discussing anything with them [nurses] and they’re there to help and I really attribute my longevity to their *care* and compassion and that is the truth.”

Essential features of the genuine caring attribute included compassionate nurses’ aptitude for (a) responding to patients’ worries, anxieties, and fears, (b) demonstrating courtesy, and (c) attending to their physical needs. Notable quotations wherein nurses addressed the emotional needs of patients included:

Owen: “I’d say in particular the first time I came in for my infusion of chemo, I was really nervous about it, I heard about all the side effects and things that could go wrong and I was clearly anxious about the whole experience. And I found that the nurses . . . helped me through the process and administering the chemo were very understanding and very attentive and they were . . . They eased a lot of my

concerns and . . . they were there and very vigilant the entire time. I'm thankful for that. It was a very stressful first day."

Vicki (Elaborating on genuine caring characteristic of compassion): "Well [nurse] took most of the fear away. There's obviously going to be some fear, but it really meant a lot to me . . ."

Several patients described nurses as nice, willing, and responsive, characteristics representing courtesy. Three salient examples were:

Genna: "I just love how they [nurses] are really nice to you like they care, shows how they really, really care about you."

Rita: "They call anybody or anything . . . that can help me . . . And they bring all the sources and resources they can have so they can help me right way."

Zack: "People [nurses] here honestly care and they go the extra mile for me, you know? And I try to be polite and not such a pain in the tuckus, but I've seen them go out of their way to make me feel good."

Finally, nurses' ability to address the unique physical needs of patients was illustrated in the following recollections:

Quintessa: "They [nurses] talk to you. Make you feel like a person and not just someone there for treatment. And they also make sure you're fed."

Wendy: "Well this is kind of embarrassing but I'm going to say it. When I was here for my surgery . . . I went to the bathroom a lot and I'd go in the bed, and these nurses were so good cleaning me up and stuff. It was just amazing how it doesn't faze them. They were just there to take care of you and keep you clean."

Listen-to-me. Most participants specifically expressed the importance of nurses' listening skills. In only one instance was the word *listen* or *listening* absent from the patient's response; however, its importance was nonetheless evident. Claire's request for nurses to *listen-to me* was stated in this manner, "And I think that, to me it's important that you do have the communication with the nurse . . . so I guess being able to talk and her understand that there was more than just me . . . feeling well. So I guess I'm openly communicating with someone."

Commonalities amongst the listen-to-me attribute spanned from providing a new nurse with compassionate care advice to a plea for nurses in general to listen with the intent of eliciting understanding and responding to their patients' desires.

Joyce: "Well it . . . it made me feel very good when somebody listened to me and could understand that what I was saying had a concern, whether it was about a complaint or something that was bothering me, whether it was pain or discomfort."

Peter: "Listen to everything the patient says, no matter how insignificant or small you think it is. To the patient, that could be monumental and it needs to be addressed like that."

Rita: "But if somebody is frightened, doesn't know what's going on, just listening helps the patient more than they'll ever realize. So just be there as a listener. They're not asking you for an answer or solution. Just let them know you're there in case anything happens."

Nursing literature supports the importance of listening to patients. Specifically, a project in Scotland was undertaken to bring compassion back into nursing practice at an

acute care setting. Nurses involved in this project deemed listening integral to patient-centered care. They believed it was imperative for compassionate nurses to “take time to speak to and more importantly, listen to patients, which helps in developing trust” (Black, 2008, p. 71).

Competent practitioner. Roach (2007) wrote:

Compassion, indispensable to the caring relationship, presupposes and operates from a competence appropriate to the demands of human care. While competence without compassion can be brutal and inhumane, compassion without competence may be no more than meaningless, if not harmful, into the life of a person or persons needing help. (p. 54)

Certainly, experiences conveyed by patients in this study corroborated with this statement by Sister Simone Roach.

Claire described a situation wherein a nurse independently ordered a CBC and the values returned so low that an immediate telephone call to the patient’s physician was warranted. The nurse simply responded to the patient’s concern that she was “really feeling down.” Claire put this experience into plain words. “She [nurse] knew there was more just by looking at me. And I felt she took the time and compassion to say to me ‘I’m going to do this.’ I know it wasn’t ordered and found out that it was something that was very necessary. And it was I feel because of her time and thinking that things were not right.”

Quintessa further explained nurse competency as “they just are on top of everything. They know their jobs.” She also shared this clinical example: “I have a power port, they know what is required to take care of or maintain a power port. And I’m

really impressed with the way I'm treated with them. When I'm on chemo, it takes a couple of hours. And I'm just impressed because of their standard procedures."

Yale's advice to a new nurse implied the need for competence. "She [nurse] has to be ready to assist people in some of the worst possible situations."

An extensive analysis of the Press Ganey database, inclusive of 3.1 million patient care surveys collected from over 2,000 acute-care hospitals in the United States, supported these patients' representation of competence as an important aspect of compassionate caring:

Patients want a caring and knowledgeable staff. They desire a skilled nurse who provides not just information but also assurance and comfort. They want members of their care team to act like a team. They want to see the cooperation and communication. And they want to know that all of this is because the staff truly care about the patient as a person. (Malott & Ayala, 2010, p. 15)

Family-like. A considerable number of patients receiving infusion therapy, primarily for cancer, described compassionate nursing in the context of an endearing, family-like relationship. The researcher immersed herself into the transcripts to ascertain these familial traits from the voice of the patient. Nurses described as family-like were those who emulated the following:

Abigail (Describing family being present): "Well, it meant a lot because my family wasn't nearby and, and I, of course you always want your family, but I felt like it was more like having family with you, you know, here, under that condition that night."

Genna (Appreciating that nurses provide love): “I felt like I was being loved, besides my family, I was like, oh wow, someone cared for me.”

Nathan (Defining family-like traits as meeting the patient’s needs): “I mean, oh, I think besides the medical part, I think, I think, they treat me so good, so I mean like my family, how to say that I don’t have much to ask for actually. They did everything. They came and, and so thoughtful and . . .” (voice too soft to record).

Wendy (Appreciating the nurses joining her efforts to combat cancer): “It’s because really I’m fighting it alone. My family is not here. And I’ve got friends here, but both my sisters are out of state. So when I come here I always like family now, you know. And they are wonderful people.”

When a patient was responding to the interview question, *how would you describe compassionate care to a new nurse*, the general consensus was to treat the patient like a family member. Sarah captured recommendations to a new nurse most aptly:

Sarah: “Put yourself in the patient’s place or imagine if the patient was a family member, whether it be your child or your parent, and how would you want that person to be treated if it were a family member? . . . Just imagine them caring for someone that they really love and I think it would probably help them kind of learn how to be compassionate with a patient, a stranger.”

Spiritual connotations. Patients’ reference to the spiritual aspects of compassionate nursing allied with literature outlining this as a professional requirement. Nurses have been taught to care for every patient according to a holistic model in which people are viewed as biological, psychological, social, and spiritual beings. Professional and regulatory guidelines require an individualized, holistic plan of care that speaks to the

spiritual needs of every patient (International Council of Nurses [ICN], 2006; Joint Commission, 2008). Some patients connected spirituality with their nurses by praying with them. Others depicted nurses as providing spiritual guidance, hope, reassurance, and exhibiting angelic qualities.

Helen (On nurses praying): “Well the nurses here have been very compassionate so I would say . . . it’s because it’s also Catholic. Because I’m Catholic and I like the way people come around and they pray with you, or give you communion once in a while, so it’s really nice.”

Wendy (On nurses providing spiritual guidance): “I couldn’t get through without any of this. You know what I mean? I couldn’t do it alone . . . And I know what I have as far as stage 4 and all this, but I have so much faith in God. My nurses - it helps me get through my journey. Nobody knows what tomorrow will bring, but as long as you have someone to help and guide you, it’s a wonderful feeling. That’s someone that cares. When I first got – my doctor told me what I had, this surgeon, most people would flip out, cry, scream, whatever. You know what? I told everybody, I’m not ashamed to say it – a peace came over me from my head to my toe the moment he said, ‘you have stage 4 cancer’ and I said, ‘Okay we’ll deal with it.’ And I’ve never – I’m not in denial. I haven’t sat home and cried or gotten depressed, but something inside of me, I have a lot of – I just can’t describe it. I know it is going to be okay. It is a wonderful feeling. And that’s all I can say, you know. It’s – and that’s not denial either. I just can’t fit it into words, the strength I feel inside of me.”

Xena (On the significance of nurse providing hope and reassurance): “Well the reassurance factor. I notice these nurses, you know, they’re always telling people, you know, ‘you’re going to be okay.’ And there’s a lot of patient’s in the area that I’m in that I, you know, think are very seriously ill and they need that, you know, that feeling of reassurance and hope coming from the staff, you know when they come into a medical procedure.”

Yale (On nurses described as angels): “We called them angels of mercy and that’s exactly what they were. It’s coincidence that . . . and I look at these girls [nurses] as angels of mercy, but I’ve always had an admiration for nurses. They’re very giving and I admire what they do.”

Some of the patients further elaborated on the spiritual aspects of compassionate care nursing during the demographic portion of their interview session, long after the recording had ceased. When queried about prayer practice, Ken was quick to inform the researcher that he was “always praising the Lord.” He prayed constantly throughout the day and, in his words, “compassion is found when you have a heart for the Lord.” Yale, an agnostic, who had “seen too many pros and cons in religion,” claimed he prayed on occasion. “There is something to be said for prayer, I know this stuff is not all physical.” He strongly believed that “religion has been commercialized over the years and is not genuine like what Billy Graham preached.”

Spread cheer. David, a cancer patient, described the relevance of being around cheerful people when he was ill.

David: “You’re not feeling fantastic and you whatever, so when you have a nurse that is cheery, that is spreading that cheer that has the good attitude, and greets you and

looks at you in the eyeball, and, and personable, you know? . . . One of your team you know, one of the hospital people, nurses probably, she had the blue stuff on, so cheery, she said 'Hi' to everybody. She said 'Good morning' to everybody. She came to the elevator, pushed the buttons for everybody. You know? And sort of cheery, spread the cheer. By the time I got to the ninth floor, she got on the eighth, I said, 'Have a great day. You're spreading good cheer keep it up.' She was in heaven, when she heard that. So it is important in a place of healing, to do that."

Positivity resonated with some patients as an important attribute of the compassionate care experience. Words that denoted nurses' favorableness included "always in good spirits," "[nurses] made light of it," "[nurses] make you laugh," and "talked to you about anything . . . you know it's funny." Cheerfulness was not an attribute noted in the literature describing compassionate care. Perhaps cheerfulness scratches the surface of the deeper need for hope that is replete in compassionate care discourse. Cheerfulness may simply reflect the patients' desire for a positive experience, a diversion from their present situation.

Contrary experiences. Suffering is the antithesis of compassion as defined in the literature. Unfortunately, a couple of the patients relaying incidences devoid of compassion caused them undue distress. These contrary experiences had such an impact that patients' went into elaborate detail recounting the unfortunate events that transpired. David: "So I feel that these nurses do exhibit a lot of compassion. That is different from my experience when I had an operation, it's different you know? Again as you mentioned after an operation and rehab and, hospital is not a good place to stay, to

rest you know? It's just too much you know? The noise and this and people [nurses] know you are drugged so they sort of treat you like an idiot. And that's not a good experience.

"So I come in 2 days ago, to this hospital, I go to the lab on the second floor, and after I wait so long, she says let me check. I said 929 is the infusion center, go up here. They, they [nurses] . . . gave me the idea that if I come in early, she calls and does all this and that. And then comes out, 'Sorry can't do nothing; you'll have to call your doctor.' Why would I have to call my doctor? 'He has to give us an order.' But I do this every month. And every month it's like no big deal it's just the same thing. 'No, no, no, no.' Of course I wasted the trip, and they track him down. The nurse says, 'oh we'll have to find him. We'll page him, we'll do this, it's a blood thing for a treatment infusion. It is no issue; it's the same procedure.' No, so anyway I left . . . I had other things to do, and I didn't have the time. But I was thinking how efficient would it be if they took my, my blood and saved the insurance and Medicare and all this and did it right?"

Quintessa: "I take Ativan® on a regular basis. I was . . . I went to the doctor's office.

She says, "you're going to the hospital.' So I just . . . gave them a list of the medications that I take. And vitamins, forget it, you know but it was a medication. And Cymbalta® and Ativan® were on there. I was given Cymbalta® but not the Ativan®. And when you have a blood infection and a bladder infection and no immune system, you're not thinking very clearly. And a couple of times my body would start to jerk. It would start in my arm and then my whole body was jerking, I was in a trance, I could see the clock. I couldn't

speak. And the nurse says, 'is something wrong?' Well, here my whole body is just twitching and jerking away; I cannot talk. And her partner asked me, 'are you finished with your dinner?' I was so upset about the incident and scared because I didn't know what was going on. Now, I have been on Ativan® for 7 years. And apparently you cannot go cold turkey. And they didn't bother to read my medications. So I was very upset with that incident. And then the next day the nurse came in and I told her what had happened and she immediately checked and she says, well, are they giving you Ativan®? And I say, 'No, I'm getting off of Cymbalta®.' And she said, 'we are starting you immediately, like, now on your Ativan® to get you back on your schedule. So I told her my schedule . . . She immediately got me stated on the Ativan® that I take on a regular basis and it helps me sleep at night.

"No one came into my room. And that's what really scared me. What if I was having a heart attack? I would have been dead."

Both of these patients described situations wherein nurses or other healthcare providers failed to care *about* them or *for* them in a personal manner. David was a well-informed patient who understood the nuances of medical equipment and his treatment. At one point during the interview session, he requested the researcher to position the intravenous pump so that he could continually monitor the infusion progress. He was articulate in describing the effect of noise in the environment, staff speaking down to him, long waits in the laboratory, as well as a frustrating clinical procedure that he believed could be streamlined for efficiency and patient satisfaction. Through the HCAHPS survey, hospitals specifically ask patients to rate the noise level and the clarity of explanations

from physicians and nurses (“explain things in a way that you could understand”; Centers for Medicare & Medicaid Services, 2007, p. 1). Press Ganey, a national administrator of patient satisfaction surveys, queries patients on the care and courtesy received during tests and treatments (Press Ganey Associates, Inc., 2004).

Quintessa shared a needless medication withdrawal experience counter to compassionate care. She was physiologically compromised as a result of a blood and bladder infection and therefore was not “thinking clearly,” rendering her completely dependent upon the nurses. An oversight in medication reconciliation resulted in undue suffering until a compassionate nurse recognized the problem and intervened.

Other contrary patient exemplars included bruising from a needle, male nurses’ rough treatment, repeatedly asking the same question, and neglecting to spend adequate time with a patient. These experiences offered a greater degree of depth and richness (Van Manen, 1990) to the essence of compassionate care. Patients had difficulty conveying compassion when their perspective was clouded with these contrary remembrances.

Setting where Compassion was Delivered

Several patients described the venue wherein a compassionate encounter between a patient and a nurse ensued. The majority of the participants experienced this type of care while receiving therapy in the outpatient infusion center where the study took place. A few patients experienced the compassionate phenomenon while receiving their very first chemotherapy infusion.

Nathan: “. . . for the first time I, I was diagnosed with lymphoma. And I did the first chemo. And actually at that time I did not feel well . . . psychologically and the

physical. And after I'd done this, one of the nurses pointed out the sunset for me, and takes me to the glasses there and watches the sunset. Actually that kind of thing makes me feel warm and pretty good."

Owen: "Well, I guess, first of all I've noticed that every time I come in, honestly I feel like I 'm greeted with quite a bit of compassion. I'd say in particular the first time I came in for my infusion of chemo, I was really nervous about it, I heard about all the side effects and things that could go wrong and I was clearly very anxious about the whole experience. And I found that the nurses were, *helped me* through the process and administering the chemo were very understanding and very attentive and they were very, what's the word, I don't know, they were very comforting.

Vicki: "Well actually when I first came here, after I was diagnosed with cancer, my first treatment, I was really nervous. One of the nurses, especially [name], she sat there, patted me on the arm, telling me things are going to be ok."

Emily narrated weekly compassionate nursing experiences in the infusion center occurring every Thursday for three and a half years. The optimal description of the outpatient infusion center's location, however, was portrayed by Florence. "I've just been coming since the . . . July. So I'm kind of learning how . . . how it works. But I . . . I've been very impressed with how nice everybody is. In fact I sometimes say it's like going to Disneyland. No matter what you do you can't make somebody be mean to you."

Other patients described inpatient settings as the location where they received compassionate care. In one notable occurrence:

Abigail: “Well I, I guess it was at night and I had been in the hospital 4 days and my blood pressure kept rising and she [nurse] came in and she sat with me because there was nothing she could really do without contacting the doctor. And she sat there with me when my blood pressure was very high, and, and it was very late at night . . . I think it was probably my first experience and that’s, it was after I had been in the hospital 4 days. So, and seeing yeah, as an inpatient and she, she just took *care* of me . . . in the middle of the night, things get kinda distorted so having someone there was very, very good for me.”

Thomas and Polio (2002) affirmed Merleau-Ponty’s aspirations for engaging in phenomenological research studies by “stir[ing] us to question our ‘knowledge’ and return to the world as we experienced it, examining the immediacy of the experience before it was classified by science and rational thought” (p. 13). Accordingly, many patients in this study associated the setting wherein they experienced compassion with its occurrence. The following reflection from Rita truly illustrated this phenomenon.

The setting for this exchange was not the routine interview room. Rita lives with chronic intractable pain and could not be physically moved until after her treatment ended. Therefore, she consented to be interviewed in a bed situated in the back of the large outpatient infusion room. The interview started with the same question, *Tell me about an experience when a nurse cared for you in a compassionate way. What did that feel like?*

The patient was soft-spoken requiring the researcher to lean over the bedside table to facilitate hearing her immediate response. Rita proceeded to describe the multiple chronic medical conditions she had endured for many years. She provided a brief

description of her extensive medical history then stated, “Most nurses were compassionate.” A long pause ensued as the researcher finished noting Rita’s comments. The researcher was caught off guard when she looked up and discovered that the patient was weeping. Her husband was sitting next to the bed holding his wife’s hand and his eyes, too, were filled with tears. Tenderly and emotionally, Rita went on to describe an incredibly endearing experience with a nurse that had the researcher in tears as well.

Rita: I’ve been in the hospital several times and most of the nurses or all of the nurses, probably I can say, they’ve always been very compassionate. Even if they’re very busy. But one time I was very, very much in pain and one of the male nurse’s . . . I can’t remember his name and I wish I did . . . he came in and *helped me* . . . lift me up with this apparatus that *I didn’t feel any pain*. And he was there to *hold my hand*. And he was very, very kind. And I said, ‘Oh, please leave me on this thing for a minute so I don’t hurt more.’ And he did. He said, ‘I’m not supposed to but I’ll leave you for a minute or so,’ and he did. So that helped me a lot. A whole lot.”

Researcher insight. The researcher envisioned Rita floating in the air, suspended in a comfortable hammock. The sling was attached to a machine, most likely a portable mechanical lift, allowing her to hover over the hospital bed. With no obvious pressure points, she discovered relief from pain. The researcher smiled thinking about the extraordinary measures one compassionate nurse undertook to allay this patient’s suffering.

Compassionate Care from the Patient Perspective

The term, compassionate care, did not require an explanation and minimal probing was necessary to derive elucidation from each patient about the compassionate care experience. All 26 patients consented to participate in the interviews without reservation after the researcher provided a brief explanation as to the purpose of the study. For example, five women in the study demonstrated a desire to participate in this process by springing out of their medical recliners, quickly rising to their feet to be heard. One of them actually remained in infusion center 10 minutes after discharge. Upon completing this interview, the researcher walked this young patient to the lobby area where family members awaited. The patient's mother sincerely thanked the researcher for taking time to converse with her daughter. While the researcher expected some trepidation and reluctance, she was pleasantly surprised that most participants seemed genuinely interested in the subject matter and sharing their stories.

Experiences and their meanings. Every recorded conversation between a patient and the researcher commenced with the question, *Tell me about an experience where a nurse cared for you in a compassionate way.* Some responses were short and succinct while others were extensive and detailed, illustrating personal incidences wherein compassionate care was rendered. The researcher probed deeper into each patient's lived experience by inquiring, *what did this feel like? What did the experience you just explained mean to you?* A few patients searched their mind and heart to provide thoughtful replies while others merely encapsulated their responses into a few words or short statements.

The researcher's final opened-ended question, *how would you describe compassionate care to a new nurse*, offered patients the opportunity to express their own conceptual definition of compassionate nursing care. Patients' responses shared many similarities, the two most common were *listen to the patient* and *provide individualized care and attention*. One patient (Peter) described his need to be heard as

Listen to everything the patient says, no matter how insignificant or small you think it is. To the patient that could be something very monumental and it needs to be addressed like that . . . I was put in hospice in 1995 and for someone to listen to me and make me feel as they're with me, . . . within my body and know that I know my body better than anybody, for them to listen to me means the world."

Florence expounded on the need for individualized care and attention:

I guess I would tell her [the nurse] to think about the patient first. Every patient I'm sure is different so some people need more reassurance. Some people just want to be left alone. They want a nap. Some people need a lot of handholding. But to try to respond to that patient's needs. And I know it's not easy to tell what . . . the patients often don't know what they need. So it takes a lot of reading of . . . signals that may be hard to read.

Upon completion of every interview session, after demographic information was recorded, the researcher offered the patient a journal with the words, *Compassionate Care*, as well as her name and contact information imprinted on the front cover. The researcher explained the purpose of the journal; to memorialize additional thoughts on the topic. Participants were encouraged to contact the researcher with additional information

related to their experiences with compassionate nursing care. No one from the study contacted the researcher after the initial interview session.

Limitations of the Study

Phenomenology research methodology does not allow for generalizability, asserting a finding as factual, or establishing functional relationships (Van Manen, 1990). For example, patients' perceptions of what constitutes compassionate nursing care may not be universal or considered relevant to patient populations outside of those who were interviewed. Additionally, findings of this study might not be shared as general truth. According to Van Manen, "the tendency to generalize may prevent us from developing understandings that remain focused on the uniqueness of human experience" (p. 22).

Patient interviews were restricted to those receiving treatment in an outpatient setting located within one faith-based hospital in Southern California. Demographic characteristics of those interviewed might have influenced the results, given that women comprised the majority of the participants and over two-thirds recounted less than two inpatient hospitalization experiences within the past year. While many patients expressed religious affiliations, no opportunity presented itself to include Jewish or Muslim patients in the study.

Audio recordings of patient interviews terminated after compassionate care experiences were relayed, leaving only questions related to demographics. Oftentimes, meaningful dialogue took place thereafter resulting in reliance upon the researcher's note taking skills, admittedly less accurate than verbatim recordings of the conversations. As a result, certain important insights may have been inaccurately scribed or absent from the

researcher's field notes and subsequently overlooked in the thematic analysis of compassionate care attributes.

Strengths of the Study

A phenomenological research method was selected to study patients' lived experiences with compassionate nursing care. The primary strength of this study was intrinsic to that methodology. Asking patients about episodes with compassionate nursing care provided insightful exemplars "pre-reflectively, without taxonomizing, classifying or extracting" (Van Manen, 1990, p. 9). Everyone interviewed generously shared his or her unique stories, anecdotes, and contrary compassionate care experiences. At no time did the researcher need to clarify the meaning of compassionate nursing care to prompt patients in their responses.

Furthermore, the researcher explored quantitative methods prior to engaging in this phenomenological study. A pilot study utilizing quantitative survey tools was unable to capture the essence of compassionate care from the individual voice of a patient, leading the researcher to the realization that actual patients' experiences were needed. Hence, employing the techniques associated with interpretative existential phenomenology was a more comprehensive approach to understanding the attributes of compassionate care from the patients' perspectives.

Significance to Nursing Practice

The daily environment wherein nurses practice has become increasingly more challenging and complex. At the point of service, nurses in acute care settings are accountable for coordinating individualized patient care, safely administering treatments and medications, ensuring clinical and professional standards are upheld to achieve or

exceed benchmarked outcomes, as well as addressing the psychological, social, spiritual, and educational needs of patients and their families. Furthermore, these expectations must be achieved within a compressed time in a fast-paced and dynamic environment.

According to Douglas (2010):

There is another less spoken of role, the role of supporting other human beings through fear, pain, loss, and the resulting impact on the patient and the care-giver [nurse]. If this aspect of the role of the care-giver [nurse] were more front-and-center, we might be better equipped to deal with the implications. (p. 416)

Practical applications. The implications for compassionate care in contemporary nursing praxis are endless. Presumably, people are drawn into the nursing profession with a clear understanding and desire to deliver compassionate care to others. However, if compassion was a universal nursing trait, then this study would be devoid of experiences contrary to this type of care. The assumption that compassion motivates individuals to become nurses and seek employment in highly personal and interactive healthcare settings may not be *completely* accurate. A multitude of opportunities for the nursing profession to further the phenomenon of compassionate care in academic and practice settings include the following:

- Screen individuals for admission into schools of nursing by evaluating their capacity to provide compassionate care.
- Emphasize compassion when teaching nursing skills. Competence includes connecting and caring; they are not merely value added. These expectations should be tied to technology *and* the emotional and spiritual aspects of a patient's

pain, brokenness, fear, and anguish. Program curricula should include real and simulated learning opportunities in this area.

- Offer didactic courses and clinical practicums on listening.
- Identify and evaluate potential hires through a compassionate care assessment.
- Provide multiple venues wherein nurses can share stories that emulate compassionate care, learning and challenging one another.
- Incorporate attributes of compassion into patients' individualized, holistic plans of care.
- Provide sabbaticals or reassignments as appropriate to nurses experiencing compassion fatigue.
- Bridge the gap in evaluating nursing practice and education and ascertain the dialogical relationship between theory and experience by conducting qualitative and quantitative compassionate care research.

General significance. This phenomenological reflective study substantiated patients' yearning for compassionate nursing care. The presence or absence of compassion in every patient's story offers countless opportunities for the nursing profession. This highlights the importance of every nurse to uphold the first provision of the American Nurses Association's (2008) Code of Ethics for Nurses: "The nurse, in all professional relationships, practices with *compassion* [emphasis added] and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, *personal attributes*, [emphasis added] or the nature of health problems" (p. 1).

Furthering the Compassionate Care Mission

Christian nursing scholars have referred to compassionate care as the nurse's ministry, focusing on "the whole person, in response to God's grace toward a sinful world, which aims to foster optimal health (shalom) and bring comfort in suffering and death for anyone in need" (Shelly & Miller, 2006, p. 244). In this data-driven world of health care, the still, small voice of the patient is crying out for compassion. Patients' testimonies reveal the need for a personal connection with a competent nurse who listens, encourages, and cherishes them like family. They desire the reassurance that tells them, in a time of crisis, they are not alone. The setting between a nurse and a patient is the mission field for compassion.

"Finally, all of you be of one mind, having compassion for one another; love as brothers, be tenderhearted, be courteous" (1 Peter 3:8).

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Appendix A

Compassionate Care Assessment Tool

Establishing a meaningful nurse-patient relationship is essential to patient care and the nursing profession. The following items describe characteristics of compassionate care, a required way for nurses to practice according to the American Nurses Association's Code of Ethics. *Compassion is understanding suffering and wanting to do something about it.* For each item presented, please rate by

Patient: Importance of each item to the term, compassionate care, from your perspective

Nurse: The extent a nurse or nurses made compassionate care apparent to you during this hospitalization

Patient				Item	Nurse			
Not important at all	Somewhat important	Very important	Extremely important		None	Some of the time	Most of the time	All of the time
1	2	3	4	Encouraged you	1	2	3	4
1	2	3	4	Showed appreciation for you/ your family	1	2	3	4
1	2	3	4	Considered your personal needs	1	2	3	4
1	2	3	4	Showed empathy for your situation	1	2	3	4
1	2	3	4	Demonstrated hopefulness	1	2	3	4
1	2	3	4	Practiced with a sense of humor	1	2	3	4
1	2	3	4	Intervened with unconditional love/respect	1	2	3	4
1	2	3	4	Remained calm at all times	1	2	3	4
1	2	3	4	Supported you/your family's spiritual beliefs and practices	1	2	3	4
1	2	3	4	Understood your medical problem(s)	1	2	3	4
1	2	3	4	Protected your privacy	1	2	3	4
1	2	3	4	Treated you without judgment	1	2	3	4
1	2	3	4	Worked competently	1	2	3	4
1	2	3	4	Helped control your pain	1	2	3	4
1	2	3	4	Acted with confidence	1	2	3	4
1	2	3	4	Skillful with equipment	1	2	3	4
1	2	3	4	Gave treatments on time	1	2	3	4
1	2	3	4	Made spiritual support available	1	2	3	4
1	2	3	4	Excused any shortcomings	1	2	3	4
1	2	3	4	Projected an inner beauty	1	2	3	4
1	2	3	4	Provided a connection with the outside world	1	2	3	4
1	2	3	4	Promoted a quiet environment	1	2	3	4
1	2	3	4	Addressed difficult issues	1	2	3	4
1	2	3	4	Sensed how to meet your needs	1	2	3	4
1	2	3	4	Took time to talk to you	1	2	3	4
1	2	3	4	Checked on you frequently	1	2	3	4
1	2	3	4	Involved you in your plan of care	1	2	3	4
1	2	3	4	Presented a professional image	1	2	3	4

Information about the patient:**Gender**

- ☐ Male
☐ Female

Year Born

- ☐ Before 1925
☐ 1925 – 1942
☐ 1943 – 1960
☐ 1961 – 1981
☐ After 1981

Marital Status

- ☐ Single
☐ Married
☐ Widowed
☐ Divorced

Reason for Hospitalization

- ☐ Medical (non-surgical)
☐ Surgery
☐ End of Life Care

Number of Hospitalizations in Last Year

Religious Affiliation

- ☐ Christian – Catholic
☐ Christian – Protestant
☐ Christian – Non-denominational
☐ Jewish
☐ Muslim
☐ None
☐ Other:
-

Spiritual Practices

- ☐ Prayer Routine
☐ Do not pray
☐ Pray occasionally
☐ Pray weekly
☐ Pray more than weekly
☐ Pray daily
☐ Pray more than once a day

Attend Spiritual/Religious Services

- ☐ Do not attend
☐ Less than once a month
☐ Monthly
☐ 2-3 times per month
☐ Weekly
☐ More than once a week
☐ Daily

Appendix B

Hospital Institutional Review Board Approval



Office for the Protection of Research Subjects

Scripps IRB11025 North Torrey Pines Road
Suite 200
La Jolla, CA 92037**Approval Notice**

Investigator: Lori Burnell, MSN

Department: Scripps Mercy Hospital

Approved

Research Sites: Scripps Mercy Hospital - San Diego, Scripps Mercy Hospital - Chula Vista

Project Title: Compassionate Care: The Patient Experience

Protocol No: IRB-10-5520

Risk Category: Minimal

Type of Review: Expedited

Your research project indicated above was reviewed and approved by an IRB officer on the review date stamped below. Approval expires **12 months** from this date.

Approval carries with it the understanding that you will inform the Committee promptly should a serious adverse reaction occur, and that you will make no modification to the protocol or consent form (if applicable) without prior IRB approval.

The IRB may suspend or terminate the approval of research that is not conducted in accordance with the requirements set forth by the committee or that has been associated with unexpected serious harm to subjects.

(Consent form dated 7/15/10; Dissertation Proposal dated 6/17/10)

Thank you for your cooperation.

Signature applied by Barbara G Bigby on 07/16/2010 12:40:41 PM PDT

IRB Officer

Appendix D

Informed Consent

CONSENT TO PARTICIPATE IN RESEARCH

Compassionate Care: The Patient Perspective

Principal Investigator: Lori Burnell, RN, PhD(c), NEA-BC
Phone: 619-260-7377

Research Site(s): Scripps Mercy Hospital San Diego & Chula Vista

Why is this research being done?

This research is being done because many nurses and hospitals have a goal to give compassionate care, but little is known about what compassion care looks like in the eyes of a patient.

Lori Burnell, RN, is asking you to participate in this study because you have been hospitalized in the past and might have received compassionate care from your nurses. By asking patients to tell their story about compassionate nursing care, Ms. Burnell will be trying to find things important to you that would describe compassionate care. This study is limited to patients having treatment in the Outpatient Clinic.

Ms. Burnell is a PhD student at the University of San Diego and this study is part of her research project. Approximately 10 people will be asked to be in this study, all of them at Scripps Mercy Hospital San Diego and Scripps Mercy Hospital Chula Vista.

How long will I be in the study?

If you want to join this study, Ms. Burnell will ask you questions about your experience with compassionate care. This meeting will take between 30 and 60 minutes of your time. The interview will take place when you are already here for a treatment. Ms. Burnell will contact you within the next 6 weeks to ask follow-up questions to make sure that she correctly describes your experience.

What will happen to me during the study?

To avoid being overheard by others, Ms. Burnell will offer to take you to a private room. The interview will be tape-recorded and Ms. Burnell may take notes to help her give a true description of your experience with compassionate nursing care. That visit may last up to 1 hour.

Could I experience any discomforts?

We do not expect that this interview will cause you any discomfort. You may skip any question that you find uncomfortable. You may also decide to quit at any time.

Will I benefit from participating?

We do not expect you to benefit directly from being in this study, but it may help nurses improve their compassionate care and that may help other people in the future.

Will I be paid?

No, you will not be paid to be in the study. It does not cost anything to be in this study.

What if I end the study early?

If you end the interview early or decide later that you no longer want to be in the study, you may ask that your information be removed from the results. Your care as a patient will stay the same no matter what you decide.

What treatments could I take instead of joining this study?

This study does not involve treatment. You can decide not to do it.

What are my rights?

- You can call Ms. Burnell at (619) 260-7377 any time and ask any questions about this study. You can also call her professor, Dr. Jane Georges, at the University of San Diego, at (619) 260-4566.
- You can decide not to be in this study or you can quit after starting. Whatever you do, your medical care at Scripps will not be affected.
- If you have any questions about your rights, call the Scripps Office for the Protection of Research Subjects at (858) 652-5500. You should also read the *Experimental Subject's Bill of Rights*, at the end of this form.
- You do not have to be in this study. You still have all your legal rights whether you join the study or not.

What about confidentiality?

Ms. Burnell will keep your personal information confidential whenever she can. Your interview will be recorded by number, not by your name, and no additional information about you will be gathered.

Future Research

The information from this study may be used for future research on compassionate care in nursing.

You will be given a copy of this form.

I agree to participate.

 Printed Name of Subject

 Phone #

Signature of Subject

 Date



Authorization to use your Private Health Information

Name of Study: **Compassionate Care: The Patient Perspective**

Principal Investigator: Lori Burnell, RN, PhD(c) **IRB Study Number:** 10-5520

What is private health information?

Private health information is any information that can be traced back to you. We need your authorization (permission) to use your private health information in this research study. The private health information that we will ask for this study includes:

- Your name & telephone number

Who else will see my information?

In addition to the Principal Investigator, this information may be shared with:

- Government agencies, such as the US Food and Drug Administration or agencies of the Department of Health and Human Services, but only at their specific request, and
- Scripps committees that review research to help protect people who join research studies.

Once we have shared your information we cannot be sure that it will stay private. If **you** share your information with people outside the research team, it will no longer be private. *Your name will not be used in any report that is written.*

How long will Scripps use and share my information?

- Your information will be used and shared until the research is completed, which we think will be in 2016.

What if I change my mind about sharing my research information?

If you decide not to share your information anymore:

- The researcher will destroy any of the private information that she already has.
- You will no longer be a part of the research study.
- You will still get the same medical care that you've always had at Scripps.

- You must write to the investigator and tell her that you no longer want to share your information. Write to the investigator at:

Lori Burnell, RN, PhD(c)
Scripps Mercy Hospital
4077 Fifth Avenue, MER-1
San Diego, CA 92103

Do I have the right to see and copy my research information?

You have the right to review the transcript of your interview and any research information gathered about you. The research information will not be part of your Medical Record that is kept at Scripps.

If you agree to share your information, you should sign this form below. You will be given a copy of this form.

I agree to share my information as described in this form

Print your name

Sign your name

Date

If you have questions or concerns about your privacy and the use of your personal medical information, contact the investigator at the telephone number listed in the consent form.

Appendix E

Interview Guide

Date: _____
Start time: _____
End Time: _____

INTERVIEW GUIDE

Compassionate Care: The Patient Experience

Definition of COMPASSIONATE CARE according to American Nurses Association's Code of Ethics:

Compassion is understanding suffering and wanting to do something about it.

Questions:

1. Tell me about an experience where a nurse cared for you in a compassionate way. What did this feel like?

2. What did the experience you just explained mean to you?

3. How would you describe "compassionate care" to a new nurse?

Closure/ Demographics:**Gender**

- ☐ Male
☐ Female

Year Born

- ☐ Before 1925
☐ 1925 – 1942
☐ 1943 – 1960
☐ 1961 – 1981
☐ After 1981

Marital Status

- ☐ Single
☐ Married
☐ Widowed
☐ Divorced

Number of Hospitalizations in Last Year

Religious Affiliation

- ☐ Christian – Catholic
☐ Christian – Protestant
☐ Christian – Non-denominational
☐ Jewish
☐ Muslim
☐ None
☐ Other:
-

Spiritual Practices

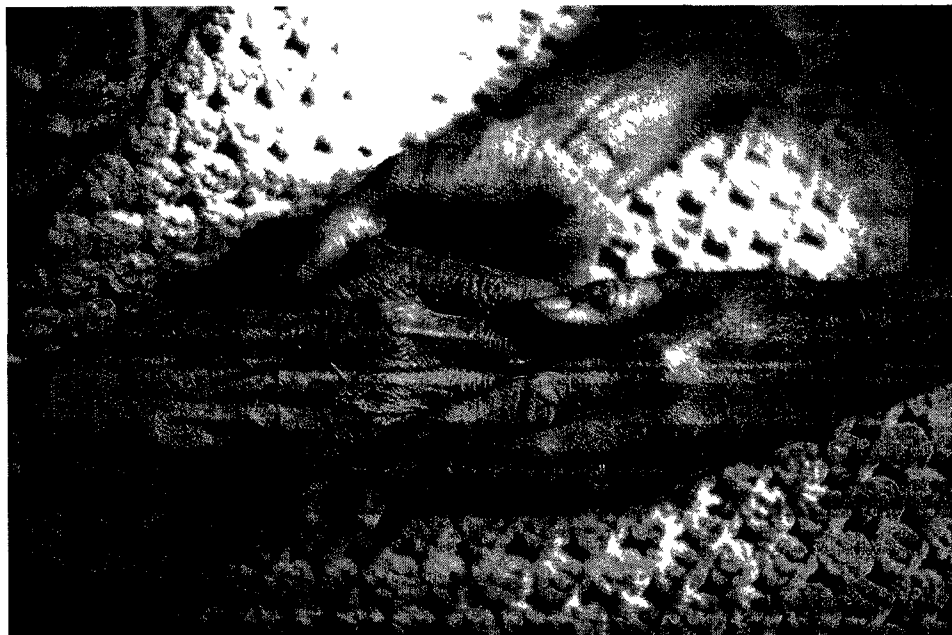
- ☐ Prayer Routine
☐ Do not pray
☐ Pray occasionally
☐ Pray weekly
☐ Pray more than weekly
☐ Pray daily
☐ Pray more than once a day

Attend Spiritual/Religious Services

- ☐ Do not attend
☐ Less than once a month
☐ Monthly
☐ 2-3 times per month
☐ Weekly
☐ More than once a week
☐ Daily

Appendix F

Recruitment Flyer

**Participants are needed in a Research Study:***Compassionate Care: The Patient Perspective*

I am seeking people who have been previously hospitalized and are currently receiving treatment in the Scripps Mercy Outpatient Clinic. I am a Doctoral nursing student at the University of San Diego conducting a study to look at people who have received compassionate care from their nurses. Participation involves an interview with me and takes about 1 hour. You will have an opportunity to see a writing copy of this interview and make changes. Participants will not be paid to be in this study. Please contact Lori Burnell at 619-260-7377 for more information or email burnell.lori@scrippshealth.org.