Relationship Between Empathy and Well-Being Among Emergency Nurses

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Introduction: A large number of patients who are in pain upon arriving at the emergency department are still in pain when they are discharged. It is suggested that nurses' personal traits and their level of empathy can explain in part this issue in pain management. The purpose of this study was to better understand the shortfalls in pain management provided by emergency nurses by considering nurses' characteristics.

Methods: A cross-sectional descriptive correlational design was used for this pilot study. French validated self-administrated questionnaires (sociodemographic characteristics, empathy, psychological distress, and well-being) were presented to 40 emergency nurses. Thirty emergency nurses completed all questionnaires during work hours. Descriptive statistics, group comparisons, and correlation analyses were used for the data analysis.

Results: Emergency nurses appear to have low levels of empathy. High levels of psychological distress and low levels of well-being were also observed in our sample. Among these variables, only empathy and well-being appear to be related, because we found higher empathy scores in nurses with higher well-being.

Discussion: The poor mental health we found among emergency nurses is alarming. A clear need exists for supportive interventions for nurses. Finally, well-being was the only variable related to empathy. To our knowledge, this is the first study to report this relationship in nurses.

Key words: Empathy; Well-being; Distress; Pain management; Emergency nurse

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J Emerg Nurs 2015;41:323-8.
Available online 10 January 2015
0099-1767

http://dx.doi.org/10.1016/j.jen.2014.10.001

In recent years, the prevalence of pain has been high in the emergency department, but unfortunately its management does not seem to be optimal. Indeed, a study showed that 78% of ED patients have severe pain (7-10 on a scale of 10), yet only 27% receive analgesia.[1] A more recent study noted gaps in pain management.[2] Clearly, at a time when multiple analgesics are available and postanalgesia monitoring can be performed via heart-monitoring devices, this lack of pain relief calls for exploration. The Fosnocht team[3] has provided one explanation: the main goal of ED care is to identify the cause of pain, overshadowing the management of that pain. Yet even after the cause has been identified, pain seems to be allowed to persist, as one study showed that 82% of patients who were in pain upon arriving at the emergency department were still in pain when they were discharged.[1] This percentage is alarming because nurses have an ethical and legal responsibility to address the experience of the person suffering from pain by assessing the presence of pain and intervening on behalf of that person's interest in accordance with the guidelines of the institution.[4]

A second possible explanation is that nurses' attitudes toward pain evaluation and relief, and how they perceive their patients' pain, may be obstacles to optimal pain management.[5] Indeed, a lack of correlation has been

observed between pain intensity in the postoperative period as documented by nurses and their patients.[6] A real difference appears to exist between the level of pain felt by patients and the level of pain perceived by their nurses. It is suggested that whether pain is treated or allowed to persist could be explained by nurses' knowledge about pain management, their personal traits, and their level of empathy as suggested by the model of Patiraki-Kourbani et al,[7] who demonstrate, after a qualitative study conducted with 46 nurses, that nurses need theoretical knowledge to treat pain, along with personal and professional experiences. That knowledge is influenced by patient characteristics and by their own personal characteristics, including their empathy level. This last hypothesis needs to be explored.

Recent studies have revealed significant gaps in nurses' knowledge about pain, particularly those working in surgery[8,9] and emergency departments.[10,11] This situation seems to have been the case for years, because such knowledge gaps were observed more than 20 years ago with regard to both pain evaluation[12,13] and administration of analgesics.[14,15] Concerning the personal traits of nurses, it is proposed that nurses underestimate pain levels because of professional detachment, a protective mechanism they have developed as a way of dealing with other people's pain.[16] Other evidence points to mental health as an explanation—that is, psychological distress could erode the empathy of medical residents[17,18] and with it the quality of care they provide.[18] In contrast, residents with better psychological well-being were found to be more compassionate and to provide better quality care,[19] while also displaying more empathy.[20] Empathy and sympathy are 2 distinct concepts that involve sharing, but whereas empathic caregivers share their understanding, sympathetic caregivers share their emotions with their patients.[21] Sympathy would be involved in the burnout of caregivers.[22] However, only a handful of studies have examined the influence of psychological distress and well-being on empathy in the context of nursing.

A study of nurses working in postoperative acute care found that they were moderately empathetic[23] but that their empathy had no bearing on the quality of their pain management. Other research has found that empathy in nursing students diminishes over the course of their studies.[24] On the other hand, a qualitative study has suggested that empathy is a key component of optimal pain management.[25] In the same vein, other researchers have observed a positive relationship between empathy and pain relief.[26] In view of this lack of consensus, more research is needed to shed light on the relationships among these variables.

The goal of our pilot study was to better understand the shortfalls in pain management provided by ED nurses. Our primary objective was to assess a group of ED nurses for their levels of psychological distress and well-being and their empathy. Our secondary objective was to explore associations among these variables.

Methods

STUDY DESIGN AND SETTING

A cross-sectional descriptive correlational design was used for this pilot study conducted with a French-speaking population. Recruiting was conducted through convenience sampling in a university hospital center located in the Province of Québec, Canada. The hospital center has 2 emergency departments at separate sites, employing 125 nurses. The 2 emergency departments combined treat close to 100,000 patients a year.

PARTICIPANTS

After obtaining approval from the Ethics Committee of the local hospital, 2 researchers (PB and SL) presented the study to the nurses in both emergency departments. A sample size of 37 nurses was calculated from the formula for an association between 2 continuous variables (empathy and well-being). We wanted to be able to detect any correlation greater than 0.40 with 80% power and a 5% α level. A total of 40 nurses volunteered, representing all 3 work shifts. Interested nurses signed a consent form, which explained the study variables and confidentiality rules. Self-administered questionnaires were completed and returned during work hours with manager permission. To ensure their anonymous status, nurses deposited their completed questionnaires and signed consent forms in separate boxes.

INSTRUMENTS

In this study, the French validated versions of all instruments were used. Sociodemographic data based on Patiraki-Kourbani et al. model were collected on the participants' age, nursing experience, years of ED work, and education level (college, university, and graduate studies).[7]

In health care, empathy is defined as a cognitive attribute involving an understanding of the patient's experience and perspective, as a separate individual, combined with an ability to communicate that understanding to the patient.[27] For this study, empathy was measured using the Jefferson Scale of Physician Empathy (JSPE).[28] This self-administrated questionnaire consists of 20 items divided into 4 dimensions: (1) adopting the patient's perspective; (2) understanding the patient's experiences, feelings, and signals; (3) ignoring the patient's perspective; and (4) adopting the patient's way of thinking. The JSPE also includes one orphan item: the value placed on empathy. Participants respond to items on a 7-point Likert scale. The total score ranges from 20 to 140.