An Exploration of Applied Liberal Education Competencies and Empathic Decision-Making in BSN Nurses

BY

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THESIS

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To my husband and children

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LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nursing
AACU	American Association of Colleges and Universities
ALECS	Applied Liberal Education Competencies Scale
ASN	Associate of Science in Nursing
BEES	Balanced Emotional Empathy Scale
BSN	Bachelor of Science in Nursing
CARE	Consultational and Relational Empathy Scale
EES	Emotional Empathy Scale
HBLE	Humanities-Based Liberal Education
HPL	How People Learn
IRI	Interpersonal Reactivity Index
JSE	Jefferson Scale of Empathy
JSE-HP	Jefferson Scale of Empathy for Health Providers
LPN	Licensed Practical Nurse
NCSBN	National Council State Boards of Nursing
NCLEX	National Council Licensure Exam
NDNQI	National Database of Nursing Quality Indicators
NSQI	Nursing Sensitive Quality Indicators
IOM	Institute of Medicine
IPOK	Integrated Patterns of Knowing
RN	Registered Nurse
RN-BSN	Registered Nurse to Bachelor of Science in Nursing

SUMMARY

The purpose of this study was to examine applied liberal education competencies and empathic decision making in baccalaureate prepared registered nurses. The specific aims of this research were to 1). examine the associations between applied liberal education competencies and empathy in the baccalaureate prepared registered nurse with a specific a focus on humanities-based liberal education (HBLE) competencies, 2). explore the perceptions of liberal education and the use of empathy in professional decision-making among BSN-prepared practicing nurses.

This dissertation includes the findings of this study presented in two manuscripts. An introductory manuscript is also included that addresses background information on empathy in nursing practice and education. The first manuscript includes findings that identify the association between applied liberal education competencies and empathy in baccalaureate prepared registered nurses. The second manuscript includes findings from narrative written reports that describe nurses' perceptions of the use of empathy in decision making as well as nurses' perceptions of the role of liberal education in this process. The appendix includes the notice of approval of human subjects research from the University of Illinois at Chicago. The author's curriculum vitae concludes the dissertation.

I. EMPATHY: MAKING IT USEFUL FOR NURSING

Empathy has long been considered a desired characteristic of the professional nurse. Empathy has been said to be the cornerstone of the nurse-patient relationship and an essential element of effective nursing practice (Doyle, Hungerford & Cruikshank, 2014; Stein-Parbury, 2013). Since early nursing theorists began to study empathy, scholars and educators in nursing have worked to define, measure and teach empathy (Peplau, 1952; Travelbee, 1971; Zderad, 1969). Nurse scientists have also attempted to draw connections between empathy and professional nursing identity, the nurse-patient relationship, and patient outcomes. However, since empathy is a broadly studied topic, both within and outside of nursing, the various and often-times ambiguous, definitions of empathy have made it difficult to find a concrete and specific use for the concept, specifically for nursing (Yu & Kirk 2008).

Overall, however, in nursing empathy has been accepted as a highly regarded, positive, professional characteristic and a major component of professional identity. Even though empathy has been written about and discussed ad nauseum in nursing, existing data relating empathy to patient outcomes are small and inconclusive. Nevertheless, empathy continues to be integrated into nursing education and practicing nurses are encouraged to use empathy in practice. However, there is limited data to support how clinical decisions are impacted by empathy as well as how empathy interventions in nursing education impact the practitioner. Although highly regarded, existing literature identifies links between different facets of empathy and burnout, emotional fatigue, and secondary traumatic stress (Crumpei & Dafinoiu, 2012; Lee, Song Young, Lee & Daly, 2003; Morse, Borttorff, Anderson, O'Brien & Solgerg, 2006).

Professional practitioners, nurse educators and researchers should thoughtfully consider existing conceptual definitions, measures, and the evidence more closely to determine if empathy

is beneficial, detrimental, or even useful for the practice of the professional nurse. For example, nurse educators often integrate teaching that will aid in the development of caring, compassionate and empathic behaviors in professional nurses. However, does this practice cause other healthcare professionals and the public to view the nurse as caring and compassionate and to overlook other highly valued nursing characteristics such as competent professional decision-making, the skilled use of best evidence in practice, and the ability to take on leadership roles? This paper is a discussion of empathy in nursing, the role it currently plays in professional identity and nursing education, and the impact it may have on patient outcomes.

Empathy: Definitions and Measures

Definitions

Empathy is recognized as having three basic definitional domains. Among these are cognitive, emotional and behavioral. Cognitive empathy is also known as trained empathy, clinical empathy, and professional empathy. There is a general agreement that cognitive or professional empathy is a clinical skill and is able to be taught, cultivated, improved and measured among health professionals and health professional students (Aligood, 1992; Cunico, Sartori, Maragnolli & Menegheni, 2012; Hojat, 2016; Kunyk & Olson, 2001; Williams, Brown & McKenna, 2013; Williams & Stickley, 2010; Wrobel, 2013; Yu & Kirk, 2008; Yu & Kirk, 2009). Emotional empathy, also termed basic empathy or affective empathy, is seen as a human developmental trait (Aligood, 1992; Hojat, 2016; Lucas, 2014).

Both cognitive and emotional empathy play a role in the nurse-patient relationship and ultimately result in professional nursing behaviors that can be observed and have been measured. However, a more recent focus has been placed specifically on the value of cognitive empathy or empathy as it relates to patient care situations, eliminating the emotional or affective aspect of

empathy. Currently accepted, and the most widely used measures of empathy, primarily reflect this type of empathy. Among professional measures, empathy has been defined as the ability to understand another's feelings and thoughts, as the ability to stand in the patient's shoes, as essential for the "help relation," as compassion, as understanding of the patient experience and perspective, and as essential for effective nursing care (Decety & Norman, 2015; Hojat & Gonella, 2015; Hojat, 2016; Lucas, 2014; Petrucci, LaCerra, Aloisio, Montanari & Lancia, 2016; Ward, Cody, Schaal & Hojat, 2012).

Due to the complex nature of the concept of empathy, there is some discussion that patient care empathy should be defined contextually, as in what is needed or desired for specific patients in specific areas of nursing practice or health care. For example, for nurses who work in palliative care, postpartum care, mental health care, or with pain management the definitions of empathy should vary to some degree (Campbell-Yeo, Latimer & Johnston 2008; Lavoie, 2015; Nyatanga, 2013; Yang, Hargreaves & Bostrom, 2014).

Definitions of empathy in popular literature also exist, are varied, and confuse even further how empathy is and should be defined. Jamison (2014) defines empathy broadly as being an imaginative inquiry without discrete edges, while McLaren (2013, p. 4) states that empathy is "a social or emotional skill that helps us feel and understand the emotions, circumstances, intentions, thoughts, and needs of others, such that we can offer sensitive, perceptive, and appropriate communication and support." Because nursing professionals are partially defined by the roles they assume in society and how they are reflected in the eyes of the patients they care for (Adams, 2012), a consideration of lay definitions is important.

Nurses spend the greatest percentage of time with patients, are often referred to as caring and compassionate, and are routinely identified as the most trusted profession (Gallup, 2015).

This is likely due to the position, disposition, and socially accepted definition of nurses. Empathy, however, from the patient or consumer perspective, appears to be missing from conceptual and operational definitions of empathy. In fact, Yu and Kirk (2008, 2009) concluded after a review of conceptual definitions of empathy and their measures in nursing, that a tool measuring empathy specifically in nursing context was necessary because of the unique nature of the patient care experience with nurses. However, currently, there is not an agreed upon definition of empathy or measures to guide the science of studying empathy specifically for nursing practice.

The distinctive nurse-patient relationship sets nursing apart from medicine, specifically where empathic behaviors are involved. In medicine, Hojat, Fields and Gonnella (2003) make a specific differentiation between empathy and sympathy, suggesting that physicians keep a compassionate detachment and sympathetic distance to avoid a situation where an emotional situation might impair physician decision-making and clinical objectivity. However, in nursing, compassion, empathy, and altruistic attachment drive some of the basic tenets of nursing care and are highly valued by both nurses and patients. In fact, empathy and sympathy are quite similar in definition although the differences in the two have been duly noted. The main difference is that empathy requires imaginative insight into a patient's suffering and the ability to see the situation from the patient's perspective (Adams, 2012). When nurses, either by nature or by learned skill, place the patient at the center of care, listen with compassionate understanding during traumatic, difficult, and even grave situations and are able to make decisions about care, it is unknown whether nurses are able to remain compassionately detached. It is also not known whether empathy and compassion are so engrained into how nurses are trained and introduced to nursing practice that they find themselves at a professional disadvantage.

Tone and Tully (2014) conclude that empathy is a "risky strength" with empathic tendencies leading to negative emotional outcomes including personal distress, interpersonal guilt, anxiety and depression. Morse and Mitcham (1997) even discuss the "contagion of physical distress" which they term "compathy." This phenomenon, not only addresses the physical response by nurses to the distress of others (i.e. feeling nauseous when observing a patient vomiting), but establishes the physical human connection between people and what they are experiencing. This would be considered the "physical component" of empathy (Morse & Mitcham, 1997). Certainly, these professional experiences and outcomes can be viewed as professionally undesirable. The need to address such outcomes and further study these in nursing to determine whether direct links are present is imperative. However, without tools that appropriately reflect a specific nursing perspective, measures will continue to be inconsistent at best (Yu & Kirk, 2008, 2009).

Measures

Empathy measures that have been used in nursing include, but are not limited to, the Interpersonal Reactivity Index (IRI), the Balanced Emotional Empathy Scale (BEES), the Emotional Empathy Scale (EES), Consultation and Relational Empathy Scale (CARE) and the Jefferson Scale of Empathy (JSE) (Cunico et al., 2012; Linn, 2011; Messina, 1995; Moulton, 1994; Nagano, 2000; Obrien, 1992; Wada & Sasaki, 2006; Ward et al., 2012; Webster, 2009; 2010; Williams, 1989; Yu & Kirk, 2008, 2009). All of these scales measure different components of what has been defined as empathy, however, the JSE relates components of being a health professional in a patient care encounter within the empathy scale (Hojat, 2007, 2016). While the JSE is focused on empathy in patient care situations, one limitation is that the primary focus of the JSE is on cognitive empathy. Furthermore, the scale was initially developed for use

with physicians and medical students (Hojat et al., 2003). Since its initial development, the scale has been slightly altered for use with healthcare professionals, nurse practitioners and nursing students. While the JSE appears to be the most appropriate and robust scale currently available to use for measuring empathy in nursing care situations at this current time, it may not actually capture the empathic essence of the art and science of nursing practice. This may be true particularly, if empathy in nursing care involves a combination of emotional, cognitive and behavioral components. This would require that all facets are reflected in an instrument used to measure empathy in nursing care.

By continuing to measure empathy in a manner where that it is currently defined for medicine and other healthcare professionals, the caring, compassionate and emotional nature of the art of nursing may be lost. If empathy, defined specifically for the professional nurse, is measured appropriately, the resulting data have the ability to aid in the further development of professional identity, enhance and standardize empathy education integration in the nursing classroom, impact patient care outcomes and potentially change the nature of the interprofessional power relationship.

Professional Identity

Professional identity in nursing has been described as "a sense of oneself that is influenced by characteristics, norms, and values of the nursing discipline, resulting in an individual thinking, acting, and feeling like a nurse" (Crigger & Godfrey, 2014). It is said that identity development initially occurs during nursing education and is molded and formed as the nurse moves from the novice role, gathers experiences and reflects upon these (Benner, Sutphen, Leonard & Day, 2010). A large component of professional identity stems from how the public views the profession and how well the professional can meet social expectations and

responsibilities set forth by the discipline (Crigger & Godfrey, 2014). Several components of professional identity have been recognized but some are very difficult to examine more closely as there is a lack of agreement to their defining characteristics as well as a lack of appropriate measures. Competence, professional decision-making, and empathy are among some of the discussed components of professional identity and when these concepts are measurable, conclusions can be drawn about how to cultivate these in the nurse early in professional education.

Competence

The term competence is among the most often used and highly respected concept professional nursing. Upon entering nursing school, students are made aware that they will be evaluated on multiple occasions, using various mechanisms, about what they have learned throughout the course of their education. This educational process all culminates in a final licensure exam designed to measure "minimal competence" (National Council State Boards of Nursing, 2015). This standardized approach to nursing education leads to a standardized approach to annual competency training and testing in healthcare facilities and the procurement of nursing certifications that are largely based on observed and executed competence, number of years in practice, and the ability to pass an exam designed to measure that competency. Nursing certifications offer a feeling of accomplishment to the professional nurse, building a sense of pride in professionalism and is directly linked to improved patient outcomes (Bloom, 2014; Boyle, Cramer, Potter, Gatua & Stobinski, 2014; Krapohl, Maojlovich, Redman & Zhang, 2010). Competence becomes ingrained in the nurses' professional identity. Even though the concept of competence is variably defined in nursing and differs greatly from institution to institution (Garside & Nhemachena, 2013), competence has become the gold standard for nursing practice.

Primarily for professional nurses, competence is centered around the ability to perform specific tasks and to master skills. In nursing education, competence has become closely associated with terms like clinical judgment and clinical decision making, with knowledge, skills and attitudes, and with the mastery of specific clinical content (McCoy, Levett-Jones & Pitt, 2013). Although Halldorsdottir (2012) has addressed compassionate competence and Labrague (2012) has discussed caring competence, empathic competence is usually congruent with emotional intelligence or emotional competence. The abundance of literature on empathy written in nursing could be an indicator that this is considered a competency of professional nursing. However, very little is written about how nurses employ certain aspects of professional identity, such as empathy in the process of making decisions about patient care.

Decision Making

Decision making in nursing involves many different aspects. Making decisions about the delivery of safe effective care is the primary focus of the undergraduate degree. As studies have shown, the educational level, compassion, caring, and empathy in registered nurses all may play a role in decisions that impact patient outcomes. However, clinical judgment and decision-making have been the focus of nursing education outcomes rather than a balance approach that represents nursing values. This is reflected in evaluative measures of practicing nurses such as licensure examinations as well as other professional certifications. The focus remains on purely technical judgment to achieve a means to an end. As Sullivan (2010) points out "unlike pure technical judgment, which employs methods to achieve pre-given ends, practical judgment involves the blending of formal knowledge with the concrete and value-laden dimensions of the situations of professional work" (p. 16). Decision making in nursing is multi-faceted and novice nurses require assistance in the development of clinical decision-making skills in practice

(Gillespie & Patterson, 2009). Knowing the profession, knowing the self, knowing the context, knowing about intuition, knowing the person and knowing the patient situation are all components of professional clinical decision-making (Gillespie & Patterson, 2009; Payne, 2015; Pearson, 2013). Some of these are reflective of what could be considered empathic competence in nursing. However, these and other components of professional identity need to be examined more closely to determine how they influence professional identity as well as how these identities have an impact on patients.

Nursing Values

In nursing there are several desired professional identity characteristics that are not competency-based or do not have standardized measures. When measures do exist, they are often confusing and/or not conceptually defined in a consistent manner (Yu & Kirk, 2009). As discussed earlier, empathy is a concept that falls among these categories. Literature in nursing suggests that aside from the cognitive and behavioral domains, nursing care involves a level of emotive understanding, compassionate concern, and the ability to communicate feelings, which are considered valued in nursing (Campbell-Yeo et al., 2008; Lee et al., 2003). All of these values have been accepted in nursing, but without data to support their concrete role, many professional nursing value standards risk being lost, poorly measured, and misused.

Nurses, due to the desire to demonstrate competence and meet professional expectations of the role, risk downplaying some of the important characteristics that differentiate nursing from other healthcare disciplines. Some even suggest that empathy, since it is a learned behavior, can be "blocked to diminish personal distress" (Campbell-Yeo et al., 2008).

Although nurses continue to struggle to find a power position within the healthcare team and command a level of respect within the global community (Allan, Tschudin & Horton, 2008),

the measures taken to meet this expectation are counterintuitive to what is socially expected of the professional nurse. Certainly, the nurse is expected to be knowledgeable, but societal expectations are often congruent with the nurse being the "angel of mercy," and the compassionate care provider. And although it is a professional expectation, the public likely puts very little weight on the idea that nurses are scientists, that nurses are working to build a cadre of evidence to improve patient outcomes, that nursing education is rigorous and demanding, and so is the practice of the professional nurse. All of these factors must be considered when nurse educators and scholars decide what is included in professional education, specifically when science takes center stage in most nursing programs and discussion of nursing values is less well-defined. Unfortunately, the lack of exposure to some nursing values may not prepare nursing students for the immense amount of social problems within the discipline, within the interprofessional and global environment, and not to mention the value-laden challenges of caring for the sick.

Nurses can use empathy and its power as a value to build grit and resolve in the face of challenge. This characteristic allows nurses to be authentic in the face of emotional situations and make difficult decisions with the patients' best interests and desires in mind. If nurses are cognitively and emotionally available and are able to harness this power to improve the authenticity of the nurse-patient relationship, it may allow them to speak honestly using the principles of empathy and empathic communication, rather than speak from scripts. Nurses draw power, strength, and respect from their ability to speak candidly to patients as they would wish to be spoken to, not in jargon, but in simple terms. Gardner (2015), a physician, writes in his account of the art of medicine that the physician and nurse used different terms to address his dying father's condition. The doctor's script was one that Gardner himself had been taught in

medical school. The nurse, on the other hand, was overheard saying to the physician in a private conference that Gardner's father "had a crappy heart." Gardner was, at first, irritated and offended by this rhetoric, but soon realized that he would much rather have an authentic presence rather than a scripted empathic delivery.

Professional Relationships and Power

In order to discuss the usefulness of empathy in nursing, a brief discussion of the relationship between empathy, gender, equity, and professional power as a component of professional identity and agency is required. The connections between these concepts have little to no representation in the nursing literature that may be important to explore further. Professional communication, and its tenets as they are taught to nursing students usually include different behavioral components of empathy (Stein-Parbury, 2013). While nurses advocate for a space of empowerment for patients, personal power is often diminished through the emotional toll of working to create a cognitive and empathic understanding of the patient perspective. Nurses are expected to care for patients who are ill and their families, and to compassionately listen and respond to those diagnosed with frightening disorders. Professional burnout and compassion fatigue have become common in nursing as well as for other caregiving professions (Lombardo & Eyre, 2011). This has become a major concern in nursing and other healthcare disciplines and is well represented in the literature (Fearon & Nicol, 2011; Rios-Risquez & Garcia-Izquierdo, 2016; Whitebird et al., 2016).

In a profession largely populated with women, gender disadvantage and lack of political support for women's roles and rights make nurse burnout and fatigue an even more pressing issue. Women tend to be more empathic, in general, and more specifically when compared to men in the same field of nursing (Cunico et al., 2012). Although men who do select nursing as a

career, showed higher levels of empathy than other males in different disciplines (Penprase, Oakley, Ternes & Driscoll, 2014). Males in nursing are paid more, and are promoted to leadership positions more quickly than their female counterparts (Muench, Sindelar, Busch & Buerhaus, 2015). This overt inequity is reflective of a nationwide issue. However, since nursing has traditionally been the work of women, this fact is particularly offensive. Because empathy has been linked to negative outcomes such as burnout and fatigue, women demonstrate higher levels of empathy, and women represent the 91% of the nursing workforce (USDHHS, 2013), empathy may place the nurse at yet another professional disadvantage as the member of the healthcare team.

Burnout and compassion fatigue may occur because there is lack of professional development support for characteristics that are developed and cultivated in response to the necessities of the job (Lombardo & Eyre, 2011). Dealing with the narratives and stories of the human condition is deep and meaningful work (DasGupta & Hurst, 2007). The imaginative and creative process that goes hand in hand with caring for the ill, understanding, and being able to imagine what it is like to stand in another's shoes may lead to emotional exhaustion at times (Gray, 2009). In nursing, is it even possible to create a professional balance between the moral obligation to provide direct care for the patient and the obligation to engage in a distanced self-interest?

Most patients will remember the name of their physician. Very few will remember the names of their nurse. Since evidence of devaluation of nurses is insidious and appears to be a global issue (Allan, Tschudin & Horton, 2008; Horton, Tschudin &Forget, 2007), then perhaps empathy, if employed in accordance with nursing values, can be used to express human power, embraced as a method of regaining privilege in a system that does not explicitly value individual

nurses. Physicians have individualized data about patient outcomes. Nurses, however, are not usually measured or considered individually, but collectively (Specht, Scherb & Loes, 2006), even though nurses provide individualized patient centered care. Practice decisions made by nurses in nursing care situations are not overt. This anonymity may impact the nurse's perception of professional power, agency and identity (Boyle, 2008).

Professional identity begins to develop during nursing education where students are exposed to multiple values that help shape their clinical practice. Since nursing education is where exposure to initial nursing values occurs, it is necessary to examine how empathy education has been incorporated into nursing education and how the outcomes have impacted student and professional development.

Empathy and Professional Nursing Education

With regard to nursing education, it is written that empathy is necessary to produce a nurse with the professional characteristics necessary to carry out the role of the nurse effectively (Doyle et al., 2014). In a longitudinal study of nursing students, Ward et al. (2012) discuss a significant decline in empathy scores as students progressed through their program toward graduation. The students who showed a more progressive decline were those who had the most clinical contact with patients (p. 37). This study reveals a need for a continued focus on empathy and an overt change to nurse preparation in professional nursing education if it is to reflect the purported nursing values.

Nurse educators have worked to incorporate creative strategies to integrate what is thought to aid in the development of empathy in the professional nurse. Several educators have integrated humanities-based content into the professional health science classroom and clinical setting to achieve empathic development and improvement. Humanities integration is not a

requirement of most nursing curricula even though humanities content integration has been found to play a role in clinical judgment, active listening, relationship building and connectedness to patients, advocacy, empathy, improved humanistic perceptions, caring, improved ability to interpret meaning, elucidation of the human experience, understanding of contexts of illness, and professional growth (Cagle, Walker & Newcomb, 2006; Capiello & Vroman, 2011; Charon, 2006; Darbyshire, 1994, 1999; DasGupta, 2007; Ferell, Virani, Jacobs, Malloy & Kelley, 2010; Frei, Alvarez & Alexander, 2010; Johnson & Jackson, 2005; Marnocha & Marnocha, 2007; McKie, 2012). These humanities learning outcomes are, in many ways, inclusive of and consistent with empathy.

Discussions of how to teach empathy during nursing and medical school are well-represented throughout the literature, specifically in the nursing literature. A variety of studies suggest different methods of empathy integration. But, there is no clear distinct standardized manner to integrate empathy into education. Empathy is also muddied alongside other concepts in nursing such as caring, compassion and intimacy (Richardson, Percy & Hughes, 2015; Walker & Mann, 2016). Several interventions have been implemented and studies with the intent of augmenting empathy development in nursing students. Low and Lascala (2014) used a medical memoir to develop empathy in nursing students studying obstetric nursing as a component of a baccalaureate nursing program. No empathy measures were used, however, student comments revealed that they were able to connect with the mother portrayed in the book and were able to see a broader view of the patient experience (p.3). These statements reflect empathy development. In a review of empathy education in nursing, Brunero, Lamont and Coates (2010) found that of the 17 studies reviewed on teaching empathy in nursing education, 11 revealed improvements in empathy, however, several limitations were noted. Among these were

insufficient sample sizes, the use of several different measurement tools, and insufficient reliability and validity of measures. Again, this suggests that consistency of empathy definition and measure in nursing are necessary.

Facets of empathy can be taught and practiced in nursing courses, as well as in the clinical environment. What is missing in the literature is a succinct connection between what is taught, either in humanities content, addressed in liberal education, or role-modeled in student-professional encounters, and how this plays a role in what the nurse does on a day to day basis, and impacts decision-making and judgments in nursing. With more evidence to support how empathy plays a role in nursing practice, curricular strategies to reflect this content will garner the necessary support. What is known is that nursing practice and the decisions nurses make change patient outcomes. What is not known is the role of empathy in the clinical decision-making process, how nurses use empathy to guide practice decisions, and how empathy impacts patient care outcomes.

Patient Outcomes

Evidence is lacking that supports a direct link between empathy as a pathway to improved patient outcomes in nursing, specifically those endorsed by nurse credentialing organizations. Commonly known and highly researched nurse specific outcomes are patient satisfaction, restraint utilization, failure to rescue, falls, pressure ulcers, medication errors, and direct care time. However, the National Database of Nursing Quality Indicators (NDNQI) and Magnet's Nursing Sensitive Quality Indicators (NSQI) both recognize that alongside patient outcomes, professional nursing structures are also of tremendous value. Among these are registered nursing (RN) certification, RN education, nursing turnover, job satisfaction, burnout,

and compassion fatigue (Erikson, n.d.; Montalvo, 2007). Among these nurse specific outcomes, only a few patient care outcomes have been studied in conjunction with empathy.

In one study of psychiatric nurses working on an inpatient unit, higher levels of empathy were associated with a reduction in seclusion and restraint of patients (Yang et al., 2014). Since application of restraints is generally considered a negative episode, this study could lend its support to empathy and its impact on patient outcomes. Lavoie (2015) discussed creation of a therapeutic relationship with postpartum women in the form of an empathic exploration of maternal views to help support breastfeeding. No data were provided, however, tenets of an empathic relationship with postpartum women have been shown to improve the nurse-patient relationship with regard to feelings of support (Lavoie, 2015).

There is more data, however, that suggests that empathic physician care impacts patient outcomes, although the evidence is neither vast or conclusive. In a study by DelCanale et al. (2012) higher levels of empathy among primary care physicians were associated with lower numbers of acute metabolic complications in patients with diabetes. This was attributed primarily to the use of empathy to create a trusting relationship. The physician-patient relationship, in turn, is thought to have impacted adherence to treatment plans and improved communication. In a study by Rakel et al. (2009) perceived patient empathy in the physician-patient encounter for those being seen for the common cold showed a shorter duration of cold signs and symptoms when empathy scores (CARE) were perfect. For healthcare providers, in general, positive cultural beliefs about health professionals lend themselves to increased perception of empathy when a patient was involved in a negative healthcare encounter such as cancer screening (Amador, Flynn & Betancourt, 2015).

There may be more data about patient outcomes in medicine due to the nature of the individual provider-patient relationship. The goes back to the idea that nursing care is provided in a team, with several nurses represented in each instance of patient care in the hospital setting. Studies have been done that link nursing characteristics to patient outcomes specifically with regard to years of nursing experience, education, involvement in professional development activities, and certification (Schuelke, Young & Folkerts, 2014). Again nurses were measured collectively and incidents on units were recorded collectively. Lack of knowledge about how to employ rigorous methods to measure individual nurses and link these characteristics directly to individual patient outcomes may be a factor that explains why this data is lacking in the nursing literature.

Summary

Even though there is a vast amount written about empathy, the data available simply do not support what is said to be of value to nursing. Empathy remains highly valued among health professionals, and is considered a feature of patient-centered care and patient-centered communication (Institute of Medicine, 2001, 2008). However, more data are necessary to support how empathy directly impacts patient outcomes, specifically nursing outcomes. This data has the potential to support the standardized commitment during nursing education to cultivating empathy during nursing education and to ensure support for healthcare providers who experience empathic decline, emotional exhaustion, compassion fatigue and burnout is sustained throughout the professional nursing workplace.

Empathy can be useful to nursing practice. It is highly valued among professional nurses as evidenced by its place in nursing literature. Nevertheless, the definition of empathy, specifically for professional nursing remains cloudy. The literature, although steadily growing in

the areas of professional identity and nursing education, does not effectively address the links between empathy and nursing specific outcomes. In short, the data on empathy, professional nursing practice identity, nursing education, and patient outcomes remain limited and reflect areas in need of intense examination by nurse scientists. Nursing is a unique discipline and therefore how empathy is defined, valued, practiced, and taught in nursing should have distinct characteristics that can only be developed through expansion of the science.

Likewise, in order for empathy to be useful for nursing, the emotional component of empathy should not be abandoned, but studied and explained. If what is desired is funding for programs that support professional identity development and maintenance and that support curricular changes in nursing that reflect the values of the profession, then it is necessary to appeal to the intellect of decision-makers, policy makers and professionals and provide solid support for our claims. Loose definitions, scattered measures, disagreements about professional identity and nursing values, and lack of a direct correlation with patient outcomes all need scientific clarification to move the matter of empathy forward in nursing practice and education.

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II. APPLIED LIBERAL EDUCATION COMPETENCIES AND EMPATHY IN BSN PREPARED NURSES

Nurse educators have long deliberated over the best approaches to teaching and learning in nursing to achieve optimal student outcomes. This is done with the intention of educating nurses who are well prepared to enter the dynamic arena of patient care, engage in concentrated empathic decision making, and function within a complex social environment (Valiga, 2012). Nursing has long been referred to as an art and a science, and the professed goals of nursing education includes a focus on student centeredness, active learning, and the teacher as facilitator in modern and postmodern curricular designs (Csokasy, 2009). Many programs have continued to use models where instruction in undergraduate nursing education has been concentrated on meeting empirical outcomes, delivering prepared lectures and using multiple choice exams as the primary evaluative measure rather than balancing the approach (Valiga, 2012). It is undeniable that a well-prepared nurse is certainly able to master pathophysiology, pharmacology and fundamental skills. However important, these valued outcomes, due to content saturation and an "overly crowded curricula" in nursing, often force the restriction of student exposure to education reflecting the art of nursing (Institute of Medicine, 2003).

The art of nursing can be viewed as an expression of nursing intelligence that includes ethical and moral commitment, sensitivity to emotion, connection with the patient, and intuition (Peplau, 1988; Price et al., 2007). These components of nursing are deeply embedded in what are considered the values of professional nursing. The values of professional nursing are highly integrated into nursing practice in all areas and the overarching and ultimate purpose of nursing education is to prepare practitioners for the practice environment. Therefore, nursing students should be educated to reflect the current values of the discipline.

As a result of the Goldmark Report in the 1920s, recommendations were made for nursing education to move from the hospital to the university setting (Varney, 2001). This meant that changes in nursing education were imminent. Nursing was no longer going to be considered a task-oriented vocation, but an educationally-driven, self-governed discipline. Almost 100 years later, with these recommendations in mind, baccalaureate curricula are developed that include a foundation of liberal education followed by professional nursing education.

The American Association of Colleges of Nursing (AACN) recommends that nurse educators make distinct connections between foundational liberal learning and professional learning (2008). However, studies show that students and faculty both struggle to link content and concepts from selected foundational liberal education courses to professional nursing practice (Hermann, Jones & Winterhalter, 2012; Peck & Jennings, 1989; Zabarowska, 1995). The intent of foundational liberal education is to provide the professional nurse with a foundation on which to scaffold the entire professional curriculum. Themes of meta-cognition, critical thinking, reflection, communication and values are found rooted within pre-professional liberal education (Bottoms, 1988; Sullivan, 2010). It is easier to appreciate the link between some liberal content and nursing, such as those courses rooted in the social sciences. However, humanities based liberal education content may be lost. When humanities content has been integrated into nursing education, the resulting outcomes are overwhelmingly positive for students. Advocacy, empathy, improved humanistic perceptions, caring, improved ability to interpret meaning, elucidation of the human experience, understanding of contexts of illness, and professional growth are among the reported outcomes (Cagle, Walker & Newcomb, 2006; Capiello & Vroman, 2011; Charon, 2006; Darbyshire, 1994, 1999; DasGupta, 2007; Ferell, Virani, Jacobs, Malloy & Kelley, 2010; Frei, Alvarez & Alexander, 2010; Johnson & Jackson,

2005; Marnocha & Marnocha, 2007; McKie, 2012). These humanities-driven outcomes are undisputedly in alignment with nursing values.

One specific nursing value that has received attention in nursing and other health professions which appears to be impacted by humanities based professional learning is empathy. This focus has led nurse educators and researchers on a quest to define and measure empathy, gain an understanding of empathy development in the nurse, the impact of empathy on professional identity, the role empathy plays in patient outcomes, and how to successfully teach professional empathy to nursing students. Empathy is considered a value of professional nursing and has been said to be a feature of patient-centered care and patient-centered communication (Institute of Medicine, 2001, 2008). In a study by Ward, Cody, Schaal and Hojat (2012), nursing students showed a decline in empathy as they progressed through nursing school. This is an indication that there is a need for a concentrated focus on empathy development throughout nursing school. With the knowledge that liberal education supports facets of empathy, some educators have integrated concepts from the humanities to cultivate empathy in students. This is not a common practice, but one that has shown positive results. However, most educators depend on humanities content delivery during foundational liberal education.

The intent of foundational liberal education in nursing is to prepare a scaffold on which to build concepts specific to professional nursing. Deep learning occurs when there is a connection drawn between what is known and new knowledge (Bransford, Brown & Cocking, 1999). In general, how the nursing student learns certain concepts like empathy and what emerges as knowledge specific to the discipline of nursing should be distinctly connected. Therefore, the process of empathy cultivation, including the influence of humanities based liberal education should be of interest to educators.

Foundational Liberal Education in Nursing

Foundational liberal education serves as the building blocks for professional nursing education. Currently, in the *Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) calls for nursing education to include a rich foundation of liberal education in the academic setting that offers students the opportunity to examine physical, social, psychological, cultural, behavioral, ethical, and spiritual issues across the disciplines. Professional nursing education components should then expand upon the liberal education required of baccalaureate nursing students. This requires students to understand the concepts introduced in liberal education from "nursing's perspective." Nurse educators are responsible for the facilitation of this translation of knowledge into professional nursing practice. The integration of fine arts, humanities, literature and sciences provide the foundation for understanding health, disease, engagement in clinical reasoning, inclusive approaches to practice, development of cultural competence, and the understanding of self and other, which contributes to safe, quality, patient-centered care (AACN, 2008, p. 11). It is thought that foundational liberal learning also supports the broader goal that students "learn how to use knowledge and reflection to inform their judgment in complex situations" (Sullivan, 2010, p. 16).

Foundational liberal education requirements may vary from program to program and courses taken may vary from student to student. However, all baccalaureate programs support foundational liberal education in the form of liberal arts and science courses. The American Association of Colleges and Universities (AACU) differentiates between liberal education and liberal arts stating that a liberal education is an educational approach necessary for students to "develop a sense of social responsibility, as well as strong and transferable intellectual and practical skills such as communication, analytical and problem-solving skills, and a

demonstrated ability to apply knowledge and skills in real-world settings" (para 1). Liberal arts, on the other hand, are the specific disciplines (para 2); which are components of a liberal education. These include disciplines within the arts, humanities, sciences, and social sciences. For this study, foundational liberal education is defined as the courses taken outside the discipline of nursing in preparation for more focused professional coursework, specifically liberal arts and liberal science courses.

In the late 20th century, several studies outlining the importance of liberal education and liberal arts courses prior to professional nursing education were conducted in an early attempt to build the case for a more highly educated nursing workforce. It was thought that this learning would also ensure that connections were being made between personal and professional knowledge and would enable nurses to effectively work with diverse populations (Vande Zande, 1995). These studies, primarily conducted in the 1980s and 1990s, reveal varied information about liberal education and the link to professional nursing practice. Some lend support to the direct connection between liberal education preparation and professional nursing practice (VandeZande, 1995; Gillis, MacLellan & Perry). However, others reveal evidence that nursing students are uncertain or confused about the link between liberal education and professional nursing and that there is little or no connection between the two (Peck & Jennings, 1989; Zabarowska, 1995). More recent studies conducted on liberal education and nursing also reveal similar reports of confusion and conflicting results related to liberal learning and professional nursing (Hermann et al., 2012).

Confusion about the meaning of liberal education has been an emerging theme. Nursing students express a lack of knowledge about the definition of liberal education and cannot clearly identify a direct connection between liberal learning and learning in nursing (Hermann et al.,

2012). In contrast, DeBrew (2010) gathered data from practicing nurses about liberal education. The responses indicated that the nurses link several professional nursing practice components with the completion of liberal education. Among these outcomes are professional decision-making and critical thinking (p. 53). Other positive perceptions of liberal education included the ability to communicate and relate to people, global thinking and well-rounded knowledge, academic growth and acceptance of diversity, as well as personal and professional growth and self-awareness (DeBrew, 2010).

This disconnection and conflicting data is disturbing because liberal learning is the cornerstone of baccalaureate nursing education and has been identified as a rich component of learning. Although the data are conflicting, the available existing evidence indicate that the liberal education component of baccalaureate nursing education leads to a more globally minded and critically thinking nurse (DeBrew, 2010; Zabarowska, 1995). How foundational liberal education impacts professional outcomes has not been examined closely in nursing and conflicting data indicate a need for a closer examination.

Humanities Learning in the Professional Classroom

Of specific concern in nursing is the disconnection between humanities learning and professional nursing education. The humanities can be described as the study of how people process and document the human experience. Since humans have been able, we have used philosophy, literature, religion, art, music, history and language to understand and record our world. These modes of expression have become some of the subjects that traditionally fall under the humanities' umbrella. Knowledge of the human experience gives us the opportunity to feel a sense of connection to those who have come before us, as well as to our contemporaries (Stanford Humanities Center A, n.d., para 1). Humanities learning offers creative and critical

thinking, cultural values, an understanding of the world around us, and the potential to bring "clarity to the future" (Stanford Humanities Center A, n. d., para. 2, 3, 4).

To support the AACN's call for nurse educators to create a direct connection between liberal education and nursing education, several educators have integrated humanities-based content into the professional health science classroom and clinical setting. Humanities integration is not a requirement of most nursing curricula. However, humanities content integration has been found to play a role in clinical judgment, active listening, relationship building and connectedness to patients, advocacy, empathy, improved humanistic perceptions, caring, improved ability to interpret meaning, elucidation of the human experience, understanding of contexts of illness, and professional growth (Cagle, et al., 2006; Capiello & Vroman, 2011; Charon, 2006; Darbyshire, 1994, 1999; DasGupta, 2007; Ferell et al., 2010; Frei et al., 2010; Johnson & Jackson, 2005; Marnocha & Marnocha, 2007; McKie, 2012). These outcomes are consistent with the various conceptual definitions of empathy that have been implemented in nursing.

Empathy has been defined and measured in nursing in various ways (Yu & Kirk, 2008, 2009). Although these varied definitions and measures have led to some confusion in nursing about how to define empathy, educators have integrated humanities-based content into professional education with positive results that support the general concept of empathy. There is some disagreement about the definition of empathy, specifically empathy in different healthcare professionals. However, for this study, specifically, empathy can be defined as being able to walk in the patient's shoes, engaging in compassionate, but emotionally disconnected care, and having the ability to understand the perspective of the patient (Hojat, 2007, 2016).

Since most baccalaureate nursing programs depend on foundational liberal education outside of the professional school for student exposure to humanities-based liberal learning content, evidence describing the role of humanities-based foundational liberal education during undergraduate preparation is crucial. An exploration of these concepts would also be useful in determining whether humanities integration throughout nursing curricula is useful on a more explicit and standardized scale. The specific aim of this research is to examine the associations between applied liberal education competencies and empathy in the baccalaureate prepared registered nurse. A specific focus will be placed on humanities-based liberal education (HBLE) competencies.

Knowledge gained from this study will help to formulate future studies of liberal learning during nurse education and development of empathy in nursing students and practicing nurses. This knowledge will also aid in the development of nursing curricula that support professional nursing values such as empathy and perhaps garner support for teaching/learning strategies that integrate liberal learning components into nursing curricula.

Conceptual Frameworks

The specific aim of this study is guided by the Integrated Patterns of Knowing in Nursing (Chinn & Kramer, 2011) and the How People Learn (Bransford, Brown & Cocking, 1999) frameworks. An examination of the associations between humanities-based liberal education (HBLE) and empathy is guided by principles of learning and knowing in nursing. How nurses learn and what nurses know conceptually must be examined to explain how nurses are educated to eventually reflect the components of professional nursing practice.

Patterns of Knowing in Nursing

Chinn and Kramer (2011) propose a model of nursing praxis which includes emancipatory, ethical, personal, aesthetic and empirical knowing. This is an expansion of Carper's (1978) Fundamental Patterns of Knowing, a seminal work on knowing in nursing. Chinn and Kramer (2011) also propose that patterns of knowing in nursing are integrated and a combination of all the proposed patterns is necessary for appropriate praxis. The patterns proposed by Chinn and Kramer (2011) are emancipatory knowing, ethical knowing, aesthetic knowing, personal knowing, and empirical knowing. According to Chinn and Kramer (2011), each pattern of praxis includes five dimensions which guide how each pattern is put into practice. The five dimensions include critical questioning, creative processes, formal expressions, authentication processes, and integrated expression in practice. However, Chinn and Kramer (2011) examined each of these patterns individually and maintain that the whole is greater than the sum of its parts. The risk of conceptual misunderstanding is imminent if the patterns are considered independently.

Emancipatory knowing. Chinn and Kramer (2011) define emancipatory knowing as "the human ability to recognize social and political problems of injustice or inequity, to realize things could be different, and to piece together complex elements of experience and context to change a situation as it is to a situation that improves people's lives" (p. 64). Emancipatory knowing includes enhanced awareness and critical examination of social injustice, inequalities, and eventually freedom from "social and political context" (p. 65). This pattern of knowing challenges the hegemonic principles at work in nursing and in the social context of "agencies" where nurses practice, educate and create knowledge.

Snyder (2014) discussed the infusion of emancipatory knowing in the nursing classroom as a means of empowering nursing students to recognize and reflect upon emancipatory knowing early in their educational process. It is expected that through the use of teaching/learning strategies in nursing, knowledge of the professional responsibilities of the nurse will improve. Ray and Turkel (2014) suggest that emancipatory nursing practice, as relational and humanistic, draws on the fundamental principles of social justice to recognize a paradox between caring in nursing and health care economics. They suggest self-care, poetry writing, aromatherapy and creating caring-healing spaces on units as emancipatory praxis. These projects are intended to offer nurses methods of reflection on the current state of affairs in nursing (p. 140).

Ethical knowing. According to Carper (1978), ethical knowing is "focused on matters of obligation or what ought to be done" (p. 29). It is a generally accepted fact that the practice of nursing is a discipline dependent on ethical knowing. However, little is presented within Carper's (1978) seminal work that offers nurses with a method to apply ethical knowing in specific clinical, educational and research situations (Porter, 2010).

Chinn and Kramer (2011) have proposed that ethical knowing involves specific actions by the nurse. These proposed actions include using codes and principles set forth by nursing, such as the American Nurses Association (ANA) Code of Ethics (ANA, 2010), to engage in a process of critical questioning. The general ethical questions that nurses may ask are "is this right?" and "is this responsible?" (Chinn & Kramer, 2011, p. 88). These stem from the nurse's own set of values that are used to guide decision-making. These questions also inspire a reflective practice in nursing where the nurse reflects upon the knowledge that guides their own ethical principles (p. 99).

Personal knowing. Since personal knowing has been identified as "the most problematic, the most difficult to master and to teach" (Carper, 1978, p. 27), routine educational practices in nursing are hardly enough to entrench all that personal knowing entails. Integration of humanities-based foundational liberal education could be an alternative. Authenticity, interpersonal relationships, and self-knowledge are all components of Carperian (1978) personal knowing. "Personal knowing requires that you be in touch with who you are and understand that who you are as a person affects your behaviors, attitudes and values both positively and negatively" (Chinn & Kramer, 2011, p. 110). Beyond this requirement, personal knowing remains obscure to practitioners.

Chinn and Kramer (2011) suggest that in acting within the domain of personal knowledge the nurse will engage in critical questioning, posing the questions, "Do I know what I do?" and "Do I do what I know?" (p. 116). Clinical judgments are influenced by what the nurse knows, knowledge of the patient, contextual information, reasoning patterns and reflective practices (Tanner, 2006). These components of clinical judgment development reflect empathic concern (Crumpei & Dafinoiu, 2012).

Aesthetic knowing. Also referred to as the "art of nursing," aesthetic knowing has historically been rivaled directly against scientific meaning where aesthetic knowledge is abstract and empirical knowledge is verifiable (Carper, 1978). According to Chinn and Kramer (2011), aesthetic knowledge does not refer to beauty as is commonly thought, but is the recognition by the viewer/listener of what is being expressed. The process of aesthetic knowledge involves the questions of "what does this mean?" and "how is this significant?" Understanding a patient's unique story through expression and having the ability to engage with this process creates meaning in the experience as a result. This definition appears to be in

alignment with the conception that empathy allows yourself to see another's point of view, to gain an understanding of another person's situation, and to act on that knowledge.

Exploration of aesthetic knowing and its process may help students to realize the subjective nature of aesthetics and seek to create meaning in the patient's experience (Hunter, 2008). Aesthetics may also enhance clinical students' abilities to create potential situational interactions and outcomes (Northington, Wilkerson, Fisher & Schenk, 2005). Through this strategy, nursing students may gain a view of human behavior and recognize how varied responses can be, including those by both the patient and nurse. According to Carper (1978), aesthetic knowing is also directly paralleled to empathy and understanding of other.

Empirical knowing. The science of nursing and the systematic understanding of phenomena are central to the practice of scientific discovery in the discipline of nursing. What can be known through direct observation and engagement with the senses is often valued over assigned meaning and individual contextual representations. Deductive reasoning and formal theoretical descriptions are predominant in empirical knowing. The lack of holism in this hierarchical approach to nursing knowledge has been criticized by those who do not ascribe to this limited approach to knowledge in nursing (Chinn & Kramer 2011; Fawcett, Watson, Neuman, Walker & Fitzpatrick, 2001; Porter, 2010).

The nurse may begin the process of engaging in empirical knowing by asking the questions, "What is this?" and "How does it work?" (Chinn & Kramer, 2011). Empirics and aesthetics are often placed on opposing sides where empirical information is that which can be directly observed and measured, and where abstract information has characteristics, but is unable to be measured sufficiently or may be indirectly observable.

Evidence-based clinical decision-making involves the conscientious use of the best available evidence (including a systematic search and critical appraisal of the most relevant evidence to answer a clinical question), combined with one's own clinical expertise, patient values and preferences, to improve outcomes for individuals, groups, communities, and systems (Melnyk & Fineout-Overholt, 2010, p. 575). Evidence hierarchies are presented that delineate levels of evidence on which nurses build systematic reviews for practice purposes (Schmidt & Brown, 2015). This method is rigorous and useful to the practice of nursing when considering evidence that addresses best practice for the prevention of pressure ulcers, central line associated bloodstream infections, or catheter associated urinary tract infections, because numeric data make sense and are applicable. However, these data are subject to amendment as new pieces of stronger evidence are discovered and are just as permeable and indiscrete as aesthetic knowledge. This process alone addresses the need for empirical information in nursing to be as adaptable as the human itself. In fact, according to Kuhn (1969), a former prominent scientific philosopher, what is certain about empirically driven knowledge is that it is inherently unstable and is as permeable to new evidence as any other type of knowledge.

Multiple patterns of knowing in nursing support the idea that knowing in nursing involves learning and integration of multiple forms of knowledge from multiple disciplines, as well as those that directly apply to nursing. Ultimately, professional nurses gain nursing knowledge during formal education and use patterns of knowing to guide how the patterns evolve and develop within the professional domain.

How People Learn

In the past, emphasis in nursing education has been placed on memory and factual disconnected learning, followed by apprenticeship style clinical learning. Very little true

connection has been drawn between theoretical and clinical learning. Nurse educators have recognized that the complexity of today's healthcare system requires that a nurse not only have the theoretical knowledge, but be able to apply the knowledge with ease in the clinical environment. In order to carry out this task, nurse educators must engage with theories of learning and examine closely how learning occurs in nursing as a specific discipline. Proposed tenets from the How People Learn (HPL) Framework may be an effective framework to guide examination of how nursing students learn (Bransford et al., 1999). This framework is intended to illuminate the basic components of learning, effective teaching strategies for engagement in learning, and the design of learning environments for optimal outcomes.

HPL has three key underlying components that serve as a guide for teaching and learning. First, people enter the learning environment with preconceived ideas about "how the world works" (Bransford et al., 1999, p. 14). If these preconceptions are not engaged in the classroom, the student may not gain a full understanding of the concepts currently being presented. For deep learning to occur, existing knowledge must be identified, acknowledged and transformed. In order for this to occur, the instructor must engage in an active inquiry to identify any misconceptions held by the student. Formative and summative assessments are also of key importance. This allows feedback to become part of the learning process.

Second, factual knowledge, contextual understanding, and knowledge organization are key to developing competence in an area of inquiry. These ideas draw upon what is known as "expertise." An expert, according to Bransford et al. (1999), has deep conceptual understanding of a subject matter, but also has an ability to connect knowledge and create patterns and relationships. This stems from a broad understanding that is not apparent to the novice. The teacher must teach in-depth knowledge of some areas of a subject rather than lightly touch on all

areas in order to enhance conceptual knowledge. Learning assessments should also reflect a depth of understanding rather than simple memorized factual information (Bransford et al., 1999).

Third, metacognition and metacognitive skill development in the learner are essential to the learning process. Creating learning goals, monitoring learning progress, and verbalization of thinking while problem solving are all components of metacognition that should be supported and examined in the learning environment by teachers and learners alike. These underlying components of how people learn should frame teaching, learning, and assessment approaches within the HPL framework.

The HPL framework also presents four "centers" of learning: learner-centered, knowledge-centered, assessment-centered, and community-centered. Within each center, Bransford et al. (1999) explains the best practices to impact learning. All of the centers are inherently linked and the best learning occurs when all are represented. Different pedagogical strategies place a different center in the foreground, although a representation of all centers is best for learning.

The learner-centered approach. The learner-centered approach (Bransford et al., 1999) to how people learn places the learner at the epicenter. One of the primary goals of the learner-centered approach is to use the knowledge that students already have and build on that knowledge linking current classroom material to what they already, conceptually, are knowledgeable about. Using a learner-centered approach requires that the instructor build a model of students' knowledge, skills, attitudes and beliefs through observation, questioning and reflection. Classroom practices may then include offering activities that call the students to deeply examine phenomena, problem solve and become aware of their own process of

metacognition (Carney, 2005). Direct instruction, lecture-based teaching, and instructor-centered activities would be examples of contrary cases of a learner-centered environment.

The knowledge-centered approach and expertise. The knowledge-centered approach (Bransford et al., 1999; Carney, 2005) to how people learn occurs when information, ideas, and skills are presented in a conceptual manner to ensure that a flexible approach to reasoning is utilized. What also may be represented in this domain is that concepts are applied to the larger domain of learning. What is taught is just as important as why this information is being taught and what expertise in the particular area looks like. There is general agreement in nursing on the common characteristics of an expert, how experts think, and the manner in which the expert applies knowledge in a practice setting.

In an integrative review on nursing expertise, Morrison and Symes (2011) discussed themes in expert nursing practice which include knowing the patient, engaging in reflective practice, risk taking, use of intuitive knowledge, pattern recognition, skilled-know how, and being emotionally involved in the domain. The environment for expert practice also must support nursing autonomy, the nurse-patient relationship, mentoring, positive nurse-physician relationships, and recognition (Benner, 1984; Morrison & Symes, 2011). The description by Bransford et al. (1999) of experts having "deep understanding of their subject matter" directly correlates with Morrison and Symes' (2011) explanation of knowing the patient, engaging in reflective practice, use of intuitive knowledge, pattern recognition, and skilled know-how.

The assessment-centered approach. The assessment-centered approach (Bransford et al., 1999; Carney, 2005) to how people learn involves continual assessment of students using a formative approach. These formative assessments allow the teacher and learner to become more aware of where the students' knowledge and understanding of a concept is and adjust instruction

accordingly. With this approach, students become more aware of their progress and teacher become more aware of how to approach instruction. Creating learning and assessment experiences that elucidate student thinking and reveal patterns and misconceptions is a specific strategy employed in an assessment-centered classroom.

The community-centered approach. The community-centered approach (Bransford et al., 1999; Carney, 2005) to how people learn takes into consideration the importance of learning context and the connection between learning context and the building of community. This approach also centers on the educator assisting students to take what is learned in the classroom and make connections to a broader context. In nursing, the broader context may include the context of the discipline of nursing, that of the practice environment, or the context of the patient narrative. In community-centered learning there is also a focus on norm establishment in the classroom. Classroom norms that place value on a deep understanding of conceptual knowledge are the preferred approach to community-centeredness.

The HPL framework has been developed for use by teachers/learners at both the K-12 level as well as into adult education (Bransford et al., 1999). These basic principles serve to guide educational strategies in the classroom that provide a strong base for future learning and development.

Summary

The IPOK and HPL Frameworks were selected to provide the conceptual guidance for this study because the aim is to examine how nurses learn and ultimately how they apply what they know in professional practice. Humanities learning within the professional nursing classroom has supported the development of empathy. Empathy development is undoubtedly a professional nursing value. Yet, most curricula in nursing do not use humanities integration in

the classroom setting and depend on foundational liberal education courses to provide the basis of this content. Coupled with the inconsistent findings of previous research, this aim of this study was guided by the following question:

What is the association between foundational humanities-based liberal education competencies and empathy?

Methods

A non-experimental, cross-sectional quantitative descriptive approach was used to answer the research question.

Selection of Participants

The eligible participants for this study were recruited via email from a roster of recent graduates from both a traditional Bachelor of Science in Nursing (BSN) program and a Registered Nurse to Bachelor of Science in Nursing (RN-BSN) program at a large Midwestern urban university. On average, approximately 160 BSN students and 40 RN to BSN students graduate from this program each year. Inclusion criteria required that respondents be able to speak English, have acquired a baccalaureate degree in nursing within the past two years, and be practicing as a registered nurse. Therefore, the sampling frame consisted of 424 recent graduates (within 2 years) from the BSN who are currently practicing as registered nurses.

A table of random numbers was used to identify 200 graduates to participate in this study. The number of participants who were invited to participate was based on the maximum allowed by permitted by Jefferson University who owns the copyright of one of the study instruments. Based on a power analysis using alpha = .05, power = 0.80, and an alternative hypothesis that the bivariate correlation will result in a medium effect size $r^2 = .30$, the minimum desired sample size is 85. A medium effect size was used because there is no prior correlation data available.

However, Polit and Sherman (1990) found that the average correlation in nursing studies was about .20.

Procedure

Participants were given four opportunities to respond to an internet-based survey. Qualtrics, a web-based platform for designed for the creation and distribution of surveys and other research services, was used to distribute this survey (Qualtrics, 2015). The survey consisted of eight brief demographic questions designed to describe the sample, followed by two measures: the Applied Liberal Education Competencies Scale (ALECS) and the Jefferson Scale of Empathy for Health Providers© (JSE-HP).

Data were collected over a period of 40 days. An initial recruitment email was sent and followed up with an email on day 10, day 20, and day 30 to thank participants and to encourage participation by those who had not yet responded. This approach was considered a modified Dillman, Smyth and Christian (2014) procedure.

Dillman et al. (2014) explain that three major categories important to reduce reluctance of participants to respond to surveys. These include building trust, decreasing costs, and increasing benefits. Trust was established through the use of a major research institution as the educational affiliation of the principal investigator, as well as through the use of a university sponsored survey platform. While there were no direct benefits to participants, the recruitment email invitation described the purpose of the study, which was to improve nursing education. A drawing for a gift card was used as an incentive to complete the survey. The internet-based survey took less than one half hour to complete and was well organized. This procedure was approved by the Institutional Review Board of the University of Illinois at Chicago.

Measures

Applied Liberal Education Competencies Scale (ALECS)

The Applied Liberal Education Competencies Scale (ALECS) (Kawczyk-Hagerty, 1989) was developed to measure how nurses apply liberal education in practice. The scale measures 10 competencies within six subscales through a self-report, survey-style questionnaire. The 10 competencies are: communication competence, critical thinking, contextual competence, aesthetic sensibility, professional identity, ethics, adaptive competence, leadership, scholarly concern for advancement of the profession, and motivation for continued learning. The six subscales include leadership, contextual practice, professional development, reflective practice, analytic practice, and aesthetic practice. Of specific concern for this study are the subscales of reflective practice, analytic practice and aesthetic practice. The definitions for these subscales fit most closely with humanities-based learning outcomes, both overall and more specifically for nursing.

Reflective practice is defined as "contemplative inquiry and action based on values and environmental considerations" (Kawczyk-Hagerty, 1989, p. 92). Analytic practice is defined by Kawczyk-Hagerty (1989) as critical thinking, or "the ability to examine situations and information analytically, rationally, and logically and draw conclusions as to their meaning and requirements for action" (p. 13). Aesthetic practice is defined by Kawczyk-Hagerty (1989) as "an appreciation of the arts and human behavior that influences interpersonal relationships and nursing actions" (p. 13). Competencies of these three subscales are measured using questions that reflect nursing behaviors. The ALECS is scored where a greater score is interpreted as a higher level of competence with regard to nursing behaviors associated with being liberally educated. Possible scores for the total ALECS scale range from 67- 335. Higher scores indicate

an overall high level of competence in applying components of liberal education in nursing practice. The subscales can be examined individually and the range for each subscale is described in Table III. Again, higher scores indicate a greater level of competence in that subscale.

The ALECS has established psychometric properties. The original reliability alpha coefficients range from 0.74- 0.91 among the six subscales. A coefficient alpha of .70 is sufficient is acceptable for new scales (DeVellis, 2003). Original construct validity was established using a contrasted groups approach and inter-index correlations. Original criterion validity was evaluated through comparison of scores on the ALECS with Schwirian's 6D Scale, a scale used to determine professional development and performance of nurses.

For the current sample, internal consistency reliability was measured using alpha coefficients (Table I). Internal consistency of the overall scale was determined (0.97), as well as internal consistency of the six subscales (0.83-0.92). An alpha coefficient is the most appropriate measure of internal consistency of the ALECS because it offers one value for a given set of data and it represents the extent to which performance on one item of the scale is a good indicator of performance on the other items on the scale (Walz, Strickland & Lenz, 2010). These data indicate that the items within the total scale, as well as within each subscale, fit together conceptually to reliably measure applied liberal education competencies. Although the ALECS has not been used to a great extent, it appears to be a robust instrument to measure self-reported applied liberal education competencies in the practicing nurse based on its original reliability and validity evaluation and internal consistency data for this study.

TABLE I
RELIABILITY COEFFICIENTS FOR ALECS AND SUBSCALES

Scale or Subscale	Average Inter-item covariance	Alpha
ALECS	0.4322073	0.9731
ALECS Leadership Subscale	0.5234058	0.9130
ALECS Contextual Practice Subscale	0.7232635	0.9279
ALECS Professional Development Subscale	0.4794830	0.8661
ALECS Aesthetic Practice Subscale	0.5842969	0.8379
ALECS Reflective Practice Subscale	0.4939361	0.9023
ALECS Analytic Practice Subscale	0.4650142	0.8864

Jefferson Scale of Empathy for Healthcare Providers (JSE-HP©)

The Jefferson Scale of Physician Empathy (JSPE) was originally developed to measure empathy of physicians and medical students in patient care settings (Hojat et al., 2001). The JSPE was based upon a comprehensive review of empathy literature and originally included 90 items. One hundred physicians were asked to offer opinions independently "about the content of the instrument, its face validity, and clarity of the text" (Hojat et al., 2001, p. 255). Using the data from the 55 respondents, the modified version of the scale was reduced to 45 items. In a follow up study, a factor analysis using data collected from 41 residents and 193 medical students, resulted in a 20 item, 7-point Likert-type scale ranging from 1(strongly disagree) to 7 (strongly agree). The 20-item factor analysis revealed four factors that are consistent with "the multifaceted concept of empathy" (Hojat et al., 2001, p. 357). These include perspective taking, standing in the patient's shoes, emotional detachment, and compassionate care.

Internal consistency reliability of the revised JSPE has been reported for both residents (alpha=.87) and students (alpha=.89). It has also been tested for use with nurse practitioners with a reliability coefficient of .85 (Hojat, Fields, & Gonnella, 2003). More recently the scale has been used with health professionals where wording was altered slightly to be inclusive of other health professionals such as nurses.

The JSE-HP© currently is designed as a three factor model. The factors include perspective-taking, compassionate care, and walking in the patient's shoes (Hojat & LaNoue, 2014). However, more recent data do not conclusively support this model. Therefore, Hojat (2016) recommends further exploratory studies among different groups of health professionals, such as nurses (Hojat, 2016; Hojat & LaNoue, 2014). For the current study, the JSE-HP© was deemed the most appropriate and robust measure. However, it should be noted, that although the scale was adapted for use with health professionals, the unique nature of the nurse-patient relationship may not be reflected in a scale designed to measure physician-patient relationships.

For the current study internal consistency reliability was measured using a Cronbach alpha. The alpha coefficient of the JSE-HP for this sample is 0.94 which indicates that the items on this scale fit together conceptually to reliably measure empathy in health professionals.

A higher score on the JSE-HP© indicates a more empathic practitioner. The potential scores for the Jefferson Scale range from 20-140.

Results

Sample

From the 200 invitations sent to request participation in this study, 74 responses were obtained for an initial response rate of 37%. Seven respondents were not currently practicing as registered nurses, so they were ineligible to participate and eliminated from data analysis. Of the 67 respondents who met the inclusion criteria, 40 completed the survey in its entirety. This resulted in a final response rate of 20%.

The mean age of the sample was 28.89 years (range = 22-51). Eight (20%) of the subjects were male and 32 (80%) were female, the average length of time as a nurse was 29.5 months. The majority of the sample reported a race/ethnicity of white (n = 26, 65%), followed by Black

or African American (n = 16, 15%) and Asian (n = 4, 10%). The majority of the sample reported that a BSN was the type of initial nursing degree earned (70%), followed by an Associate of Science in Nursing degree (25%). Twenty-two (55%) of the 40 subjects were graduates of a traditional bachelor of Science in Nursing program and 15 (37.5%) were graduates of a RN-BSN program. The primary practice area represented by 40% sample was medical-surgical nursing (n = 16). Four participants reported completion of a bachelor degree prior to earning their degree in nursing. The demographic characteristics of the sample are presented in Table II.

TABLE II

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS (N=40)

Characteristic	M	SD
Age at time of survey in years	28.9	7.1
Length of time as a nurse at time of survey in months	29.5	24.8
Characteristic	**n**	**%**
Gender		
Male	8	20
Female	32	80
Race/Ethnicity		
American Indian/Alaskan Native	1	2.5
Asian	4	10
Black or African American	6	15
Hispanic or Latino	3	7.5
White	26	65
Type of initial nursing degree earned		
License Practice Nursing Degree	1	2.5
Associate of Science in Nursing	10	25
Bachelor of Science in Nursing	28	70
Diploma Nurse	1	2.5
Type of BSN program attended		
Traditional Bachelor of Science in Nursing	22	55
Registered nurse to Bachelor of Science in Nursing (RN-BSN)	15	37.5
Bachelor of Arts or Bachelor of Science to Bachelor of Science in Nursing	3	7.5
Primary practice area		
Medical Surgical	14	40
Oncology	1	2.5
Intensive Care (ICU)	4	10
Emergency Room	3	7.5
Orthopedics	1	2.5
Labor and Delivery/Women's Health	3	7.5
Pediatrics	3	7.5
Other	9	22.5
Intermediate Care (IMCU)	0	0
Surgery	0	0
Hospice	0	0
Other bachelor degree		
Yes	4	10
No	36	90

Applied Liberal Education Competencies Scores

The participants' scores on the ALECS were calculated in total. The participants' scores for each subscale were also calculated. The mean score for the ALECS was 191.2 with a standard deviation of 44.9. The mean scores on the ALECS subscales ranged from 18.8 - 42.7 (Table III).

Jefferson Scale of Empathy for Healthcare Providers Scores

The participants' scores on the JSE-HP were calculated in total. The mean score on the JSE-HP was 115.9 (Table III).

TABLE III
SCORES ON THE ALECS, ALECS SUBSCALES, AND JSE-HP©

Scale or Subscale	M	SD	Possible Score Range
ALECS	191.2	44.9	67- 335
ALECS Leadership Subscale	39	10.7	14- 70
ALECS Contextual Practice Subscale	27.5	9.7	11- 55
ALECS Professional Development Subscale	26.8	7.4	10- 50
ALECS Aesthetic Practice Subscale	18.9	5.9	7- 35
ALECS Reflective Practice Subscale	42.7	10.4	14-70
ALECS Analytic Practice Subscale	34.5	7.2	10-50
JSE-HP©	115.9	20.4	20-140

Associations between Liberal Education Competencies and Empathy

To determine the associations between foundational humanities-based liberal education competencies and empathy, data were analyzed using Stata 14.0. In particular, Pearson's correlation coefficients were used to determine if an association could be made between empathy as measured by the JSE-HP and self-reported liberal education competencies as a whole or on any of the subscales. Since the aim of this study focus on humanities-based liberal education competencies, special attention was given to the ALECS subscales of aesthetic practice, reflective practice and analytic practice as these reflect the specific goals of humanities learning.

No statistically significant correlation was noted between applied liberal education competencies and empathy with this sample of baccalaureate prepared nurses based on total scores of the ALECS and the JSE-HP© (Table IV). However, a weak positive correlation (r^2 = .25) was noted between the two concepts. Likewise, no statistically significant correlation was noted between the JSE-HP© and the ALECS aesthetic practice or ALECS reflective practice (r^2 =.21 and r^2 =.29). Although these weak linear correlations do not reveal statistical significance, there may be value in further exploration of these facets of humanities-based liberal learning.

A statistically significant correlation was found between the JSE-HP© and the ALECS analytic practice ($r^2 = 0.44$, $p < 0.05$). This indicates that there is a moderate linear relationship between empathy and analytic practice behaviors that are related to liberal learning.

A linear regression model analysis was conducted to determine the amount of variance in empathy scores that could be explained by analytic practice. The regression model was statistically significant ($F = 9.19$, $p = 0.0044$) with an R^2 of 0.193 which indicates that 19% of the variance in empathy scores was explained by the analytic practice scale of the ALECS.

TABLE IV

CORRELATIONS FOR SCORES ON ALECS, ALECS SUBSCALES, AND JSE-HP©

Measure	1	2	3	4	5	6	7	8
1. ALECS Total	--							
2. JSE-HP© Total	.25	--						
3. ALECS Leadership	.88*	.18	--					
4. ALECS Contextual Practice	.88*	.10	.71*	--				
5. ALECS Professional Development	.89*	.14	.78*	.82*	--			
6. ALECS Aesthetic Practice	.81*	.21	.57*	.81*	.67*	--		
7. ALECS Reflective Practice	.94*	.29	.78*	.77*	.80*	.74*	--	
8. ALECS Analytic Practice	.73*	.44*	.62*	.42*	.53	.49*	.74*	--

*Note. * coefficients are significant at p<0.05*

Discussion

The purpose of this study was to examine the associations between applied humanities-based liberal education (HBLE) competencies and empathy in the baccalaureate prepared registered nurse. Although there were some weak correlations found between the ALECS aesthetic practice and ALECS reflective practice scales which may best reflect HBLE, these results were not statistically significant. However, the ALECS subscale measure of analytic practice was found to account for approximately 20 percent of the concept of empathy as measured by the JSE-HP©.

The ALECS subscale measure of analytic practice is defined as consistent with critical thinking (Kawczyk-Hagerty,1989). This is of importance to nursing because there is a lack of concrete data to support factors related to professional empathy in nursing and how empathy may play a role in decision-making and thinking in practice situations. Additionally, these data may provide backing for the fact that liberal education alone may not be enough to support the desired characteristics of the professional nurse.

While caution must be taken because of methodological limitations, the results still hold potential meaning. Future studies that include an examination of empathy and liberal education in nursing with larger, more inclusive samples are necessary to determine whether or not significant correlations between the two concepts exist. A concentrated study of nurses who were recipients of humanities-based education while in their professional programs might also be useful to determine if this specific group demonstrates different results. An exploratory study of how practicing nurses use empathy in practice decision-making may be useful given the finding in this study that supports a moderate correlation between analytic practice and empathy. These future studies would aid in the clarification of the relationship between the concepts of HBLE

and empathy as well as garner data from nurses about their perceptions of the use of empathy in practice and the role it plays in professional decision-making.

Patterns of nursing knowledge and how they are used in practice continue to incite questions about how nurses are educated to reflect these patterns (Chinn & Kramer, 2011). The focus on exam and licensure pass rates ensures that there is adequate representation of empirical knowing. However, personal, aesthetic, ethical, and emancipatory knowing are all necessary for competent practice. These patterns of knowing are found in humanities-based liberal education content and this content should be threaded through nursing curricula to ensure that the entry-level nurse is educationally prepared for professional practice. Optimal learning environments provide learner-centered opportunities to engage knowledge from past learning within a community of similarly educated peers (Bransford et al, 1999). These principles are missing in nursing education, specifically with regard to the connection between humanities-based liberal education and professional nursing education.

If liberal education, specifically content rooted in the humanities is said to be of value to nursing, then this should be reflected in the content delivered in the professional school. There is an association between liberal education and critical thinking in this sample of practicing nurses. However, although there are data to support that humanities learning in the nursing classroom supports empathy, this is reflected in this study examining humanities-based foundational liberal education and empathy. Since, nurse educators depend primarily on foundational liberal education for the delivery of humanities-based content, then opportunities are being missed to integrate humanities-based content and augment the development of professional characteristics, such as empathy, as well as to potentially address what has been recognized in empathic decline in nursing students (Ward et al., 2012). As a component of humanities learning, reflection and

reflective writing have been shown to build empathy, help students identify with and make connections to patients, improve professionalism and enhance professional communication (Branch, 2010; Kind, Everett & Ottolini, 2009; McMillan-Coddington, 2013). The integration of a reflective writing humanities component organized specifically at the time when empathic decline appears to be the greatest in nursing students may also be of use to assuage this empathic decline.

Strengths and Limitations

As with all research, there were strengths and limitations noted. The sample was a convenience sample that was obtained from a registrar list of recent graduates from two campuses of the same university. Convenience sampling increases the risk for introduction of bias, as subjects may not be typical of the population of interest (Polit & Beck, 2008). For this sample, this may also be the case as subjects were drawn from the same university and were educated following similar curricula which may not reflect baccalaureate program graduates, in general. This limits external validity and generalizability of the results.

A strength of the sampling method was that subjects were randomly selected from a sampling frame that included the entire available population from this location. This random process strengthened the convenience sampling method by limiting researcher selection bias and increasing generalizability to a small degree (Creswell, 2009; Polit & Beck, 2008). A power analysis completed prior to this study revealed the need to obtain a sample of 85 to obtain statistical power (alpha = .05, power = .80). An alternative hypothesis that a bivariate correlation will result in medium effect ($r^2 = .30$). A medium effect size was selected because no prior correlation data are available. However, Polit and Sherman (1990) found that the average correlation in nursing studies was about .20. The resulting sample (n = 40) was small which

produces less accurate results and increases the possibility of sampling error. Of 67 responders who met the inclusion criteria, only 40 completed the entire survey. There was also potential for response bias. A wave analysis was not completed of responders and non-responders week by week. To strengthen this study, a wave analysis should have been completed to determine if responses by non-respondents would have substantially changed the results of this study (Creswell, 2009).

Survey data was gathered through a self-report questionnaire. This survey specifically was designed to gather information about specific experiences which makes self-report the most appropriate method (Creswell, 2009). Survey was the most appropriate method of data collection for this study because it allowed for a simple way to contact several individuals and seek their participation. The turnaround of data collection was rapid and the costs were minimal. A potential limitation of this method is that instruments, the ALECS and JSE-HP© were combined to create the survey. This places a limitation on some of the original reliability and validity data for the scales (Creswell, 2009). However, the current reliability data indicate that the scales were internally consistent. Another limitation of survey methods, in general, is the low response rate (Dillman et al., 2014). For this study, the original response rate was 37%, the sample that met the inclusion criteria reduced this rate to 34%, and ultimately, the response rate was 20% after a total case analysis was implemented. This low response rate limits representativeness of the sample (Fincham, 2008).

Conclusion

Overall, there were strengths and limitations of this study. The data from this study provide some information about humanities based liberal education competencies and how they relate to empathy in the recently graduated baccalaureate prepared nurse. The potential focus of

future studies on liberal education related to professional nursing practice and humanities-based liberal education and the potential impact on empathy and decision-making in nursing are topics for future studies. Future studies done to examine these topics with larger samples from multiple schools of nursing are necessary to draw stronger associations between the concepts.

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III. EMPATHIC PROFESSIONAL DECISION-MAKING AMONG BSN PREPARED NURSES: DOES LIBERAL EDUCATION PLAY A ROLE?

Introduction

The ability to engage in competent professional decision making in a complex environment is a requirement of professional nursing practice. Dowding et al. (2011) points out that all of the terminology used to describe how nurses make decisions in practice are concepts that are closely related, yet distinct. For example, critical thinking is defined as the skill that is "pre-requisite" for all decisions made in professional nursing practice whereas clinical reasoning is the process by which information and judgments are used to inform decisions made in practice (Dowding et al., 2011). Critical thinking, clinical reasoning, clinical judgement and decision making are often times used interchangeably in the nursing literature, resulting in confusion in meaning and description. This is especially important for nurse educators who are interested in which factors impact the process of decision making by nurses in patient care situations. Improved knowledge about what underlies decision making in professional nurses will assist educators in developing interventions for use during undergraduate nursing education.

Moreover, decision making in nursing is complex. In addition to technical care decisions, the nurse is often faced with ethical issues, and emotional decisions (Dowding et al., 2011). What is not completely certain is for different types of decisions, how decision making develops in the nursing student and eventually continues to develop in the professional nurse. What is also unknown are all of the factors that play a role in professional decision making in different clinical situations. Therefore, the specific aims of this study were to explore the perceptions of liberal education and the use of empathy in professional decision-making among BSN-prepared practicing nurses.

Background

Decision-Making in Nursing

Making decisions about the delivery of safe effective care is the primary focus of the undergraduate degree in nursing. In undergraduate nursing education, emphasis is placed on critical thinking, clinical judgment, and decision-making, linking nursing action to patient outcomes. The National Council Licensure Exam (NCLEX) for registered nurses aims to measure clinical decision making skills in the form of a comprehensive exam that integrates nursing knowledge with prioritization. "Knowledge skills and abilities" are tested that ensure minimal competency of the practicing nurse (National Council State Boards of Nursing, 2015). The focus of this licensure exam is purely technical judgment outside of the actual care environment. Although this exam identifies the minimally competent nurse, the education of a nurse involves more than content and preparation for these types of practice decisions. In fact, there have been 10 different types of judgement or decision situations identified in nursing practice (Thompson & Dowding, 2009). Furthermore, as studies have shown, many factors play a role in how decisions are made about patient care (Dowding et al., 2011; Tejero, 2012).

In a systematic review of educational interventions that address decision making and judgement in nursing, the results demonstrate that educational interventions, thus far, are unpredictable, unstable, and often times counterintuitive (Thompson & Stapley, 2011). From this review, it is recognized that educational interventions play a role in decision making in the nursing student. However, from what is currently available, conclusive evidence is lacking.

After graduation from programs of nursing, novice nurses require assistance in the development of decision-making skills in practice (Gillespie & Paterson, 2009). Knowing the profession, knowing the self, knowing the context, knowing about intuition, knowing the person,

and knowing the patient situation are all components of professional decision making in practicing nurses (Gillespie & Paterson, 2009; Payne, 2015; Pearson, 2013). Novice and experienced nurses are required to engage in decision making addressing a multitude of patient needs and concerns. Since all decisions made in nursing are not focused on the strict use of technical judgment, then multiple factors should be considered when examining the process of making decisions (Dowding et al., 2011). When a patient problem is highly technical or well-defined, the decision-making process is highly task-oriented and based in positivism (Welsh & Lyons, 2001). However, much of the decision-making that occurs in nursing situations, specifically situations that are "experiential, understanding, or hermeneutic" rely on cognitive, affective, behavioral and intuitive aspects (Thompson & Stapley, 2011; Welsh & Lyons, 2001). The education of the professional nurse should reflect these aspects.

Liberal Education

Liberal education preparation is said to impact critical thinking and judgement skills (Sullivan, 2010). As Sullivan (2010) points out "unlike pure technical judgment, which employs methods to achieve pre-given ends, practical judgment involves the blending of formal knowledge with the concrete and value-laden dimensions of the situations of professional work" (p. 16). Professional baccalaureate education in nursing usually consists of foundational liberal education courses in the arts and sciences followed subsequently by professional education courses focused in nursing. Foundational liberal education has also been said to be the cornerstone of baccalaureate preparation for professional nursing practice (AACN, 2008). Nurse educators are encouraged to create nursing curricula that scaffold upon foundational liberal education courses in the arts and sciences. However, there is usually a distinct division drawn between liberal education and professional nursing education even though the baccalaureate

standard implies that liberal education should be distinctly connected to and integrated within nursing education (AACN, 2008).

Studies in nursing that examine the role of liberal education in nursing focus on student and faculty perceptions of coursework that impacts nursing care (DeBrew, 2010; Hermann et al., 2012). Confusion and conflicting results related to liberal learning and professional nursing have thus far been the results. Confusion about the meaning of liberal education and lack of knowledge about the definition of liberal education were reigning themes (Hermann et al., 2012). However, students were able to express that there was value in liberal learning but none identified that any direct connection was made between liberal learning and learning in professional nursing. In contrast, DeBrew (2010) found that nurses linked several professional nursing practice components with the completion of liberal education programs, including professional decision-making, the ability to communicate and relate to people, global thinking, self-awareness, and acceptance of diversity, as well as critical thinking (p. 53). One of the purposes of foundational liberal education in baccalaureate nursing curricula is to provide the student with a foundation for developing critical thinking which is a crucial underlying component of decision-making in nursing (Dowding et al., 2011).

In fact, when liberal arts and humanities learning has been integrated through the professional education component of both nursing and other health science programs, including medicine, it has been shown to have positive outcomes for practitioners (Charon, 2006; Darbyshire, 1994; DasGupta, 2007; Marnocha & Marnocha, 2007; McKie, 2012). Much of the literature on these outcomes is centered around themes that reflect components of empathy as well as the desired outcomes of applied liberal learning. In an exploratory study by Adams (2016), the analytic or critical thinking involved with applied liberal education competencies in

nursing was moderately positively correlated with empathy in BSN prepared nurses. Since liberal arts and humanities content integration is not standard in programs of learning in nursing and empathy has been shown to decline as nursing students progress through programs of study (Ward, et al., 2012), how then does liberal education, play a role in the use of empathy in decision making by professional nurses?

Empathy

Empathy has been defined and measured in various different ways in nursing. This alone makes it difficult to find a definition and a measure that fits well with the complex nature of nursing practice (Yu & Kirk, 2008, 2009). Empathy has been said to be cognitive and behavioral, and in several studies, has been identified as emotional intelligence (Shanta & Gargiulo, 2014). Empathy has been defined as the ability to understand another's feelings and thoughts, as the ability to stand in the patient's shoes, as essential for the "help relation," as compassion, as understanding of the patient experience and perspective, and as essential for effective nursing care (Aligood, 1992; Cunico, Sartori, Marognolli & Menegheni, 2012; Decety & Norman, 2015; Hojat, 2016; Kunyk & Olson, 2001; Lucas, 2014; Petrucci, LaCerra, Aloisio & Montanari, 2016; Ward et al., 2012; Williams, Brown & McKenna, 2013; Williams & Stickley, 2010; Wrobel, 2013; Yu & Kirk, 2008, 2009). When measured in the health professions, there is a more recent focus on the value of cognitive empathy as it is related to the health care provider-patient relationship, in essence, diminishing the emotional or affective aspect of empathy.

The nurse-patient relationship is different from relationships with other healthcare providers, specifically where empathic behaviors are involved. In medicine, Hojat et al. (2003) makes a specific differentiation between empathy and sympathy, suggesting that physicians keep a compassionate detachment and sympathetic distance to avoid a situation where an emotional

situation might impair physician decision-making and clinical objectivity (Cited by Adams, 2016). In nursing, compassion, empathy, and altruistic attachment drive some of the basic tenets of nursing care. This is highly valued among both nurses and patients. In fact, empathy and sympathy are quite similar in definition although the differences in the two have been duly noted. The main difference is that empathy requires imaginative insight into a patient's suffering and the ability to see the situation from the patient's perspective (Adams, 2012). When nurses, either by nature or by learned skill, place the patient at the center of care, listen with compassionate understanding during traumatic, difficult, and even grave situations, it is unknown whether nurses are able to remain compassionately detached and unemotional in patient care situations, specifically situations that involve decisions that are less technical and involve a greater range of ethical involvement.

Conceptual Frameworks

This research was guided by the Integrated Patterns of Knowing (Chinn & Kramer, 2011) and How People Learn (Bransford, Brown & Cocking, 1999) frameworks. Integrated Patterns of Knowing (IPOK) in nursing is a framework that highlights the different ways knowledge is used in nursing, what knowledge is valued, and how this knowledge shapes how nurses examine, organize, and respond to phenomena (Carper, 1978). Building off of Carper's (1978) seminal work on fundamental patterns of knowing in nursing, the patterns of knowing, proposed by Chinn and Kramer (2011), include emancipatory knowing, personal knowing, aesthetic knowing, ethical knowing, and empirical knowing. Each of these patterns has specific value in nursing practice.

Emancipatory knowing is the recognition that nurses have knowledge of the social forces at work in unjust or unfair situations. Emancipatory knowing is involved in nursing advocacy,

when nurses advocate for themselves by engaging in self-care, or advocate for patients who are involved in a socially unjust situation. Personal knowing involves knowledge of self as well as a deep understanding of other. The nurse engages in the interpersonal process and knowledge of self is crucial to gaining an understanding of the patient and becoming effective within he nurse-patient relationships. Aesthetic knowing is referred to as the art of nursing (Carper, 1978). This pattern of knowing involves the subjective knowledge of the "direct feeling of experience" (Carper, 1978). Aesthetic knowing is also most closely aligned with empathy in nursing practice. Empathy, according to Carper (1978), is controlled by detachment to ensure objectivity. However, meaning is created through this pattern from subjective experiences which may become more clear as the nurse becomes more skilled (Carper, 1978).

Empirical knowing is the science of nursing. Objective clinical information is the basis for decisions and knowledge that may be acquired within this pattern of knowing. Heavy scientific questions, technical patient care situations, and evidence-based protocols are largely rooted within this pattern of knowing. However, Chinn and Kramer (2011) warn that this pattern should not be considered independently without other nursing knowledge because it could be misconstrued as too rigid. Ethical knowing is also referred to as moral knowing (Carper, 1978). Chinn and Kramer pose that the nurse might ask in an ethical situation "is this right" or "is this responsible?" This stems not only from the Code of Ethics set forth for nursing practice, but also from the nurse's own sense of values, specifically where patient care decision-making is concerned.

The How People Learn (HPL) framework is borrowed from the learning sciences. This framework addresses four centers of learning that need to be present for deep learning to occur (Bransford et al., 1999). Among these centers are the learner-centered approach, assessment

centered, knowledge centered, and community centered. The learner-centered approach is about placing the learner at the center of education. The educator working from this center identifies characteristics about the learner, including the learner's prior knowledge, and then adjusts methods and techniques to best align learner characteristics with teaching techniques. The educator builds off of the knowledge that the learner has acquired, essentially scaffolding new knowledge built upon the student's knowledge foundation.

The knowledge-centered approach ensures that the knowledge that is being presented and explored is presented in a conceptual manner where multiple learners are able to apply flexible reasoning techniques to the knowledge at hand. The community-centered approach is the approach that included techniques that ensure that the student in learning in context. This also is important so that students are able to draw connections between concepts across different contexts. An example in nursing is when students learn in the context of the classroom and later apply conceptual knowledge in the clinical setting. The assessment-centered approach is the process of using formative assessment so that the instructor has the opportunity to become aware of the student's level of understanding of the concept being addressed. This center allows for clarification of the students' patterns of thinking as well as misconceptions in thinking (Bransford et al., 1999).

These theoretical frameworks are both appropriate for application to this research because an examination of empathic decision-making in nursing practice involves patterns of knowledge in nursing. The other component of this research involves an examination of how BSN prepared nurses view the impact that foundational liberal education has on this process.

Research Questions

This research will be guided by the following research questions:

Among baccalaureate nursing graduates 1) how are principles of empathy employed in professional decision-making? and 2) how does undergraduate liberal education coursework play a role?

Method

Study Design

The data for this study were obtained from responses to open-ended questions that were posed to baccalaureate prepared registered nurses in a larger descriptive study designed to measure applied liberal education competencies and empathy. The survey involved two quantitative scales (Applied Liberal Education Competencies Scale [Kawczyk-Hagerty, 1989]; Jefferson Scale of Empathy for Healthcare Providers© **[**Hojat, et. al, 2003], as well as a set of open-ended response questions.

The open-ended questions were designed using the major factors of standing or "walking in the patient's shoes" and perspective-taking" which are defined by the Jefferson Scale of Empathy for Health Providers (JSE-HP©) as facets of empathy, specifically in the patient care situation. Participants were asked about which courses taken during nursing education helped them to engage in empathic decision-making. A question was also posed about which other factors are perceived as playing a role in empathic decision-making. The open-ended questions are presented in Appendix A. Permission to conduct the study was granted by the University of Illinois at Chicago Institutional Review Board.

Participants

Of the 40 original responses that met the inclusion criteria and were used in data analysis procedures, eight (n = 8) respondents completed the open-ended questions. All were female, with an average age of 30.1 years (range = 23-41) and an average practice time of 42.4 months (range = 12-98 months). Of the eight participants, four identified as their initial nursing degree being a Bachelor of Science in Nursing (BSN), three reported an Associate of Science in Nursing (ASN) and one reported a Licensed Practical Nursing (LPN) Degree. A summary of the participant characteristics is presented in Table V.

TABLE V
PARTICIPANT CHARACTERISTICS (N=8)

Age	Sex	Race/ Ethnicity	Primary Practice Area	Length of Time as RN (in months)	Original Degree	BSN Degree Program
41	Female	Asian	Other	72	LPN	RN-BSN
36	Female	Black or African American	Medical-Surgical	24	BSN	Traditional
24	Female	White	Other	24	BSN	Traditional
37	Female	White	Medical-Surgical	98	ASN	RN-BSN
26	Female	White	Other	35	ASN	RN-BSN
23	Female	White	ICU	12	BSN	Traditional
24	Female	White	Other	26	BSN	Traditional
30	Female	White	ICU	48	ASN	RN-BSN

Note. Intensive Care Unit (ICU), Licensed Practical Nurse (LPN), Associate of Science in Nursing (ASN), Bachelor of Science in Nursing (BSN), and Registered Nurse to Bachelor of Science in Nursing (RN-BSN).

Content Analysis Procedure

The written responses to the open-ended questions were analyzed using the content analytic procedure described by Miles, Huberman and Saldana (2014) and Saldana (2016). The

initial analytic step was to read and review the written responses multiple times on multiple occasions. Once this process was completed, the formal data analysis began with first cycle coding to initially place data into coded categories and code mapping to place first cycle codes into broader categories or emerging pattern codes. Second cycle coding was used to derive pattern codes and final themes from the data (Miles et al., 2014; Saldana, 2016).

Results

Six pattern codes or themes were identified from the content analysis. The final themes that emerged from the content analysis will be discussed in this section and are summarized in Table VI. In addition, the first cycle codes are presented in Appendix B (Table VII) and a code map (Figure 1) is presented in Appendix C.

TABLE VI
PATTERN CODES/THEMES DERIVED FROM SECOND LEVEL CODES

Pattern Code/Theme	Constituent Codes
Professional Characteristics	Experience matters Passion for helping Advocating
Value-laden Situations	Situational sense of moral duty Ethical challenges
Personal Knowing	Personal history Knowing the patient Hearing the patient If it were me
Emotional Connection	Connected emotionally Internal scaffolding I know how it feels
Standing in the patient's shoes	Relating to people From a different perspective
Empathic Perceptions	Because I used empathy Education impacts decision making

Professional Characteristics

Professional characteristics emerged as a pattern code or theme with this sample of nurses. When written narratives by the nurses were reviewed and analyzed, three different characteristics of the professional nurse were described: 1) experience or the amount of time spent in the health care environment, 2) a passion for helping or statements that indicated the nurse helps in any way one can, and 3) advocating or speaking on the patient's behalf.

Experience matters. When asked about factors that impacted their ability to stand in another's shoes, four out of the eight nurses described that they perceived experience as playing a major role. Experience was described primarily in terms of time spent in the healthcare field. "Working in healthcare from the age of 19 has played a significant factor." Other nurses stated

that “years of experience as a CNA,” and “a lot of experience” were important in their ability to stand in the patient’s shoes and understand situations from the patient’s perspective. This experienced mattered in their ability to use empathy to guide decisions made in patient care situations.

Passion for helping. Another professional characteristic that impacted the nurse’s ability to stand in the patient’s shoes was “a passion for helping.” This in vivo code was derived from a statements such as “I have developed a passion for helping others, so it’s easy for me to put myself in their shoes.” Other statements that reflected a passion for helping included personal desires for improved patient outcomes such as “I wanted the patient transferred to the ICU and I wanted him to get a unit of platelets.”

Other statements were similar, but reflected actions that may not directly impact the patient outcome, but indicate helping behaviors. One nurse said that in an interaction with a patient at the end of life she “held his hand as he was getting closer to death, said prayers in his ears, played soft music at his bedside, and didn’t allow him to die alone.” Other statements indicated helping behaviors associated with the professional nurse role such as “I was still going to take care of him and do my job” and “I always try to be with my patients especially those who do not have any family or friends.”

Advocating. Advocacy is considered a role characteristic of the professional nurse and from this sample of nurses, it is reflected in how they made decisions about patient care. This makes a difference especially for situations where the nurse is being asked to describe how they were able to stand in the patient’s shoes and understand from the patient’s perspective. “I kept advocating for the patient” and “I advocated for him and helped him find a more comfortable alternative to aggressive medical intervention.”

These two statements also reflect how nurses advocate in the face of adversity. The first statement is indicative of the need to continue an advocacy role even though a positive outcome was out of reach. The latter statement was about support for the patient's wishes rather than the desire of the treatment team. Another nurse demonstrated her dedication to the professional role as advocate with the recognition that the nurse may be the only party speaking on the patient's behalf. "I will not stop advocating for my patients because sometimes the only voice they have to speak up for them is me, their nurse."

Value-Laden Situations

When asked to describe a situation where the nurse used empathy in decision-making in a nursing care situation, all participants identified situations that were value-laden, or situations that invoked a sense of duty.

Situational sense of moral duty. Patient care situations did not reflect purely technical aspects of nursing practice and reflected a sense of moral duty to these individuals. One nurse participant explained an end of life situation with an "elderly gentlemen, no family, no friends…anoxic brain injury. Terminal wean ordered." Another respondent described a value-laden situation where the patient was in the hospital with an exacerbation of "CHF and nonstemi." Empathy was perceived to have been used in this situation because the patient "was suffering from depression and his wife had passed six months ago" and this patient "did not want interventions." Other nurse narratives of patient situations included "a patient admitted for alcohol detox" and a patient whose "wife was on the oncology floor a few floors below dying of cancer."

Ethical challenges. A component of value-laden situations in nursing also includes times that nurses find ethically challenging to their value system. These nurses expressed that they

found it difficult to stand in the patient's shoes and understand from the patient perspective when patients come to the hospital but "refuse treatments even after being educated on why they are important." "I have a hard time relating to my drug abusing patients" wrote one nurse which suggests that nurses perceive challenges involving patients whose decisions and values are not in alignment with their own.

Another nurse expressed that there are challenges to caring for patients when unable to stand in their shoes, but "if you cannot honor their wishes you seek out the charge nurse and request an assignment change for ethical reasons." As an alternative to seeking reassignment, other strategies were also used to deal with ethical challenged. One nurse said, "I try not to spend as much time in the patient's room talking because I simply do not know what to say" whereas another nurse "tried to educate the patient as much as possible about their situation."

Personal Knowing

In this study, the nurses were asked what factors play a role in the ability to stand in the patient's shoes. Statements made by the nurses reflect facets of personal knowing. Personal knowing reflects the idea that nursing actions are influences by personal history that impact present care decisions and nursing actions. Also included in the pattern code or theme are knowing the patient, hearing the patient, and "if it were me."

Personal history. When asked to express what makes it easier to stand in the patient's shoes or see things from the patient's perspective, nurses responded by saying that personal history was a factor. For example, one nurse stated that a "(s)ignificant family history of cancer has made me acutely aware of pain and suffering," while another nurse said, "I have a family member who experienced the same struggle." Both of these statements suggest that these nurses

find that personal experience with a situation makes it easier to provide empathic care. Likewise another nurse stated,

> "My father died in a single MVA on a lonely road in the middle of the night. The severity of the crash supposedly killed him instantly but no one can really be sure being that he was found hours later. I hate the thought that if he had not been killed instantly and lingered for even a few minutes, the thought of him being alone in the darkness haunts me."

The intimate narrative that guides decision making in certain patient care situations, reflects that what goes into deciding about patient care and using empathy in patient care for certain nurses involves very personal knowledge.

Knowing the patient. When asked about standing in the patient's shoes and understanding the patient's perspective, the nurses expressed that an understanding of the patient's situation was necessary. The awareness in these situations is not because the patient directly told the nurse what was occurring but because nurse was using outside knowledge and an intuitive sense to help guide care decisions in these cases. One nurse "understood the anxiety he was feeling," and another stated, "sometimes patients need to feel like they are not the only ones dealing with certain situations." These expressions indicate that knowing the patient oftentimes involves using personal knowledge.

Hearing the patient. This form of personal knowing is introduced when the nurse is able to act because she can hear and understand what the patient is saying. One nurse said that "hearing their stories about their daily lives and struggles" helped her to stand in the patient's shoes. When making decisions about caring for a patient struggling with understanding their

diagnosis, one nurse indicated that "I told her to please tell me or any other healthcare provider if she was confused or had questions about anything."

If it were me. This in vivo code was drawn from the powerful reflection by a participant who stated "I wondered how would I feel if it were me and I received limited healthcare just because of my status."

Emotional Connection

The nurse narratives about standing in the patient's shoes and understanding the patient's perspective during patient care reflect the emotional component of providing nursing care to seriously ill patients. The codes included in this theme are connected emotionally, internal scaffolding and "I know how it feels."

Connected emotionally. Nurses expressed that caring for patients sometimes involved intense emotional connection. "The emotional connection between myself…and this patient is what really allowed me to care for this patient in a special way." This connection also reflects how nurses and patients create relationships and the subsequent impact on outcomes. One nurse said that the "human relationship takes health improvement even further," thus would approach the situation the same manner in the future. Another nurse expressed that "(b)ecause of this emotional connection, I was able to listen to the patients' needs, to their desire to improve one's health and well-being."

The nurses' narratives also reflected how emotion was demonstrated. For example, one patient was described as "being tearful and upset" while another patient "had struggled for years" and "just felt lost." These statements are reflective of the patients' emotional expression of need as perceived by the nurse participants.

Emotional recognition and connection in some situations, allowed the nurse to make a decision about patient care that was not technically paramount, but served the specific patient situation. A patient expressed how "weak and worthless he felt" and "I allowed this patient to wear another O2 device that did not keep his oxygen saturation where we wanted it, but it allowed him to talk to his daughters."

"I felt bad," "I was frustrated," and "he made me quite miserable" are statements made by nurses that also indicate an emotional response to caring for patients. They also suggest that nurses consider these patient statements and experiences as examples of being able to stand in the patient's shoes and understand the patient's perspective in nursing practice.

I know how it feels. The nurses in this study were able to describe an understanding of feelings and emotions when patients experience certain situations. For example, "(b)eing unable to breath or the feeling of unable to breathe can increase anxiety" for patients. In addition, "it is very frustrating, overwhelming, and frightening when you don't know why things are being done to you and you feel as if no one will explain them." Another nurse said that one "man needed to feel like he was still able to make decisions for his wife and that he was not as worthless as he was feeling." Another nurse expressed that "no one entered this world alone and no one should die alone."

Internal scaffolding. Internal scaffolding represents a nurse behavior that is distinct from personal knowing where the personal story was shared with the patient with the hopes of a better outcome. This was in alignment with what the nurse perceived as using empathy in a patient care situation. One nurse expressed that "by giving a sense of hope and encouragement, and sharing my personal story with the patient had a positive outcome on the patient." This is not only related

to the idea that the nurse felt a sense of personal connection to the patient, but was able to go a step further and express this to the patient through the sharing of the personal story.

Standing in The Patient's Shoes

Standing or walking in the patient's shoes is a common definition of empathy in patient care situations (Hojat, 2016). Nurses expressed, when asked about situations where they would stand in the patient's shoes that relating to people and being able to see from another perspective were both components that aided in their ability to effectively stand in the patient's shoes and use this to guide decisions about care.

Relating to people. This sample of nurses used the term related, relation, and relationship on several occasions. One nurse said that her use of empathy was because "I've always enjoyed trying to relate to people in every interaction in my life, so empathy is something that comes very natural to me." Another stated that "medicine only goes so far, the human relationship takes health improvement even further." Since the perception that relating to the patient impacts the ability to stand in the patient's shoes and to use this information to guide patient care decisions, then relating may be a necessary component of professional nursing care. Others said "I was able to relate" and "they (the patient) need to feel a relation."

From a different perspective. Viewing the patient care situation from a different perspective involves the use of the patient perspective to be able to stand in their shoes. Nurses stated when asked about standing in the patient's shoes that "it allows me to see from a different perspective, one that I believe I would not be able to see." Another expressed that when she stands in the patient's shoes, she is able to "think twice about making assumptions about people and instead try to view things from their perspective.

Empathic Perceptions

Empathic perceptions are belief statements about what the nurse perceives to have occurred due to the use of empathy in practice. This theme also included nurse's perception of liberal education preparation that impacts professional decision making.

Because I used empathy. Some nurses stated that they would not change their actions even if knowing that the ultimate outcome for their patients would not change. "My actions for the patient did not change the outcome. However, I like to think that I made a difference." Another nurse commented that even though the outcome was unknown, "I'm glad I stepped up." Others spoke to the idea that their actions did change the outcome. For example, it was commented that, "after this, I feel my patient and I could both trust each other more." Another nurse said that "I was able to encourage this patient and create a sense of hope to persevere through this situation."

Education impacts empathy. Nurse respondents did perceive that there were courses, specifically pre-professional courses that impacted their ability to stand in the patient's shoes and see things from the patient's perspective. Of the eight responses, six nurses mentioned psychology courses as having an impact on their ability to stand in the patient's shoes Psychology "helped me better understand the way the mind operates," "allow[ed] me to better understand others' perspectives, and "really gave me a lot of insight." Other nurses reported that courses in ethics, music, and teaching/educational courses were beneficial and "helped to broaden my thinking and help me think in many different ways." Other courses such as "sociology was helpful in teaching me about what most people experience" while anthropology was found to be of importance because it was perceived as teaching the nurse to "observe how

they (patients) act aside from what they say." Life span and history courses were also mentioned but without a description of how the nurse perceived these courses as beneficial.

Discussion

From this descriptive data, when nurses were asked open ended questions in survey format about a time when they were able to stand in the patient's shoes and understand the patient perspective, six themes emerged. The nurses identified that professional nursing characteristics were some of the factors that allowed the nurse to stand in the patient's shoes and understand the patient's perspective. Experience as a nurse, a passion for helping, and advocacy were all characteristics that were represented in these data. Experience in nursing has been studied at length and has been theoretically and empirically shown to impact nursing practice, specifically decision making ability (Benner, 1984; Cone & Murray, 2001). It is known that nursing students experience empathic decline throughout the course of nursing education, specifically as they are exposed to patients to a greater extent (Ward et al., 2012).
Since the expressions by this group of nurses indicate that experience plays a role in the ability to effectively use empathy in professional decision making, then perhaps empathy may "rebound" as the nurse transitions from student to practitioner and gains practice experience. Further development of knowledge in this area may include a longitudinal study of empathy beginning while the student is in school and through the first five years of practice.

The nurses also identified that value-laden situations were times when the ability to stand in the patient's shoes and understand their perspective was of importance. However, the nurses also expressed ethical challenges where they found it difficult to use empathy in decision making. Ethical knowing, also a recognized pattern of knowing in nursing (Carper, 1978; Chinn & Kramer, 2011), reflects that moral situations where there is no distinct boundary between right

and wrong, may emerge in nursing. Ethical codes (ANA, 2010) and principles may be used to guide decision making, but decisions made in situations as these often press the boundaries of using codes and standards to guide decision making (Carper, 1978).

Emotional connection and personal knowing were themes that directly support the unique nature of the nurse-patient relationship, specifically where affective and emotive understanding are concerned. Personal knowing is a common theme found in nursing and has been identified as a pattern of knowing in nursing (Carper, 1978; Chinn & Kramer, 2011). Personal knowing is the key element in the formation nurse patient relationship and this authentic knowledge requires human engagement with the patient (Carper, 1978; Chinn & Kramer, 2011). Since personal knowing is the "most difficult to master and to teach," perhaps clarification of when personal knowledge plays a distinctive role in decision making for professional nurses would be useful (Carper, 1978).

Standing in the patient's shoes was a theme that was not chosen prior to data analysis, but emerged to fit a previously defined facet of empathy. The nurses wrote about relating to people and seeing the situation from a different perspective. These are both in alignment with one of Hojat's (2016) definitions of empathy. However, it is also important to recognize that the nurses' responses may have been informed by the questions asked earlier in the JSE-HP© component of the survey.

The nurses indicated that their perceptions of the use of empathy decision making may have been informed by different courses taken in liberal education and that the decisions made using empathy had an impact on patient care. The nurses reported that several courses taken in liberal arts and sciences had an impact on decision making. Psychology was mentioned by far to the greatest extent. Anthropology, ethics, music and history were also among the courses

included in the responses. The nurses were able to point out that liberal arts and science courses outside of nursing indeed impact professional decision making, specifically where empathy is concerned. Earlier studies that examined liberal education, not specifically related to an outcome indicated that nurses value specific courses taken outside professional nursing education and can see a connection to nursing practice (DeBrew, 2010; Herman et al., 2012). The social sciences were the most highly represented responses with this group of nurses. This reflects the How People Learn framework knowledge-centered and learner-centered concepts (Bransford et al., 1999). Nursing education should be clearly built upon foundational liberal education and according to HPL, prior knowledge should be built upon using a scaffolding approach beginning with what the learners already know.

Nurse responses also indicated that using empathy in decision making impacted patient outcomes. There were no true "clinical" outcomes mentioned as being impacted, however, quality of life, satisfaction, trust and hope were among the underlying concepts.

The data from this study support the idea that decision making in nursing is multifaceted and complex (Dowding et al., 2011). These data also suggest that when nurses consider situations where decisions are based on standing in the patient's shoes and understanding the patient's perspective that the situations are usually laden with values and the professional characteristics of the nurse are perceived to play a role. Emotional connection to the patient is one of the most exciting findings from this study as most measures used in healthcare aim to eliminate this from empathic decision making to maintain objectivity. For the nurse, this appears to be paramount to decision making in value laden situations and liberal education may play a noteworthy role. These data support the idea that liberal education should be threaded through

the nursing curriculum because these courses may be of greater value in aiding the development of the decision making process if viewed from the nursing perspective.

Value-laden situations are many in nursing care. These nurses articulated situations where values played a role in how decisions were made about patient care, rather than on technical interventions. These situations were not strictly about technical decision making, but the complex nature of the patient care situation. Reflections about the patient's situation indicate that value-laden situations that require decision-making that may involve facets of empathy. On the other hand, these nurses also expressed, when asked, that there were times when it was more difficulty for them to stand in the patient's shoes and understand from the patient's perspective.

Strengths and Limitations

A strength of this study is that the data collected were rich descriptive data about the use of empathy in the decision making process of nurses. Rich, thick description was also conveyed in the findings which allows for a feeling of "shared experience" and supports the validity of the results (Creswell, 2009). Another strength of the study was that some of the identified codes were formed using direct quotes from the participants. This "in vivo" coding method also add validity to the results (Creswell, 2009; Miles et al., 2014).

One major limitation of this study is that the perspective of using empathy in decision-making, involved narrative responses from only the nurses. Information about how the patient and/or the patient's family and friends viewed the nurse's role is lacking. These patient and family perceptions would be useful for further study in this area.

Another limitation is the survey design. Although the benefit of survey design is that a large group of participants can be reached using fairly little time and financial resources (Polit & Beck, 2008), one limitation with the collection of narrative data from open ended questions is the

lack of ability to follow up with the participant. Narrative responses gathered in a face to face interview may lead to further questioning on specific topics, for clarification, for further explanation, and for the acquisition of more in-depth knowledge.

Although the sample size was adequate to obtain rich description and in-depth narratives, there were no responses from male nurses. Male nurse perceptions may vary and different information may have been represented since males are known to have lower mean scores on average on empathy measures (Hojat, 2016).

Conclusions, Implications, and Recommendations

In nursing, "different judgement tasks are suited to different thought processes…matching the two can optimize decision-making" (Standing, 2008, p. 124). Value-laden and ethical situations require decisions that have multifaceted approaches. Certainly all of the situations in this study were starkly different, however, the nurses identified that they used empathy while making decisions in all of these cases. Since all of the situations included in the participants' narratives were value-laden, this reinforces that idea that "groups of judgement or decision tasks share certain characteristics" (Thompson, Aitken, Doran & Dowding, 2013). These specific situations appear to reflect that nurses use empathy often-times in situations that only can be experienced in "real-world" settings.

Nurse educators work to expose students to simulated and clinical-based situations where nursing students are able to practice clinical judgement and decision-making, however, value-laden situations may be more difficult to expose student to. This may be where the imaginative process involved in liberal arts and humanities education in nursing has a specific place. According to these data, nurses are exposed to a variety of value-laden and ethical situations. Most of these cannot be simulated and may not be experienced during clinical training of the

nursing student. These situations require imagination, preparation, and a firm backing on which to guide decisions. Foundational liberal education, specifically content that is threaded through nursing curricula may be helpful in developing these skills.

Future studies on liberal education and the impact on decision making are necessary to further explore this topic. Future studies that examine the longitudinal patterns of empathy in nursing students and nurses will also be useful as determinations are made about the factors that play a role in the decision making process of registered nurses. Decision making in nursing is complex and multifaceted and simple knowledge of technical care decisions is not enough for the real-world practice of the professional nurse.

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APPENDIX A

OPEN-ENDED RESPONSE QUESTIONS

1). The following inquiry asks you to describe a situation in some detail. Describe a time when you were able to stand in the patient's shoes and understand the perspective of the patient with regard to clinical care.

a. Please describe the situation, any relevant patient details (ie age, condition), any relevant personal details, and what it was about the situation that allowed you to stand in the patient's shoes.

b. Please describe how your ability to stand in the patient's shoes and understand his/her perspective influenced at least one of the decisions you made about the type of care to deliver in this situation.

c. Please describe your decision and provide you opinion about whether the outcome of the situation was made better or worse, or was not affected by your ability to stand in the patient's shoes. Explain the reason for your response.

d. If you had the opportunity to repeat this situation would you do it again the same way? Please explain your reason for saying this.

2). Have there been instances in practice when you have felt incapable of understanding a situation for the patient's perspective? If so, please describe the situation and how it impacted the delivery of care.

3). Think about the non-nursing courses that you took during your educational preparation to become a nurse. What courses helped you develop your ability to stand in the patient's shoes and understand his/her perspective?

4). Aside from your educational preparation, what other factors have impacted your ability to stand in the patient's shoes and understand his/her perspective? Please describe how each factor has played a role.

APPENDIX B

Table VII

FIRST CYCLE CODES AND DEFINITIONS

Code	Definition
Experience matters	Mention of the amount of time spent in the healthcare environment
"Passion for helping"	I help in any way that I can
"Advocating"	Speaking on the patient's behalf
Situational sense of moral duty	Description of a patient situation where decision making was not guided by purely technical judgement
Ethical challenges	Statements about the challenges of being able to stand in the patient's shoes
Connected emotionally	Statements indicating that there is emotion involved in the process of caregiving
I know how it feels	Statements reflecting intimate caregiver knowledge of the situation
Internal Scaffolding	Prior personal stories are shared with the purpose of impacting the patient
Personal history	Statements about past personal experiences impacting present decisions and actions
Knowing the patient	Because I know the patient situation, I am able to act with empathy
Hearing the patient	Because I listen to the patient and hear their story, I am able to act with empathy
"If it were me"	Caregiver personalization of the patient situation
"Relating to people"	The ability to relate to people plays a role
"From a different perspective"	Statements about viewing the situation from the patient's perspective
Because I used empathy	Belief statements about what occurred because of the use of empathy in professional decision-making
Education and empathy	Statements about coursework outside of nursing that are believed to impact empathy behaviors in nurses
Faith	Caregiver faith plays a role when walking in the patient's shoes

APPENDIX C

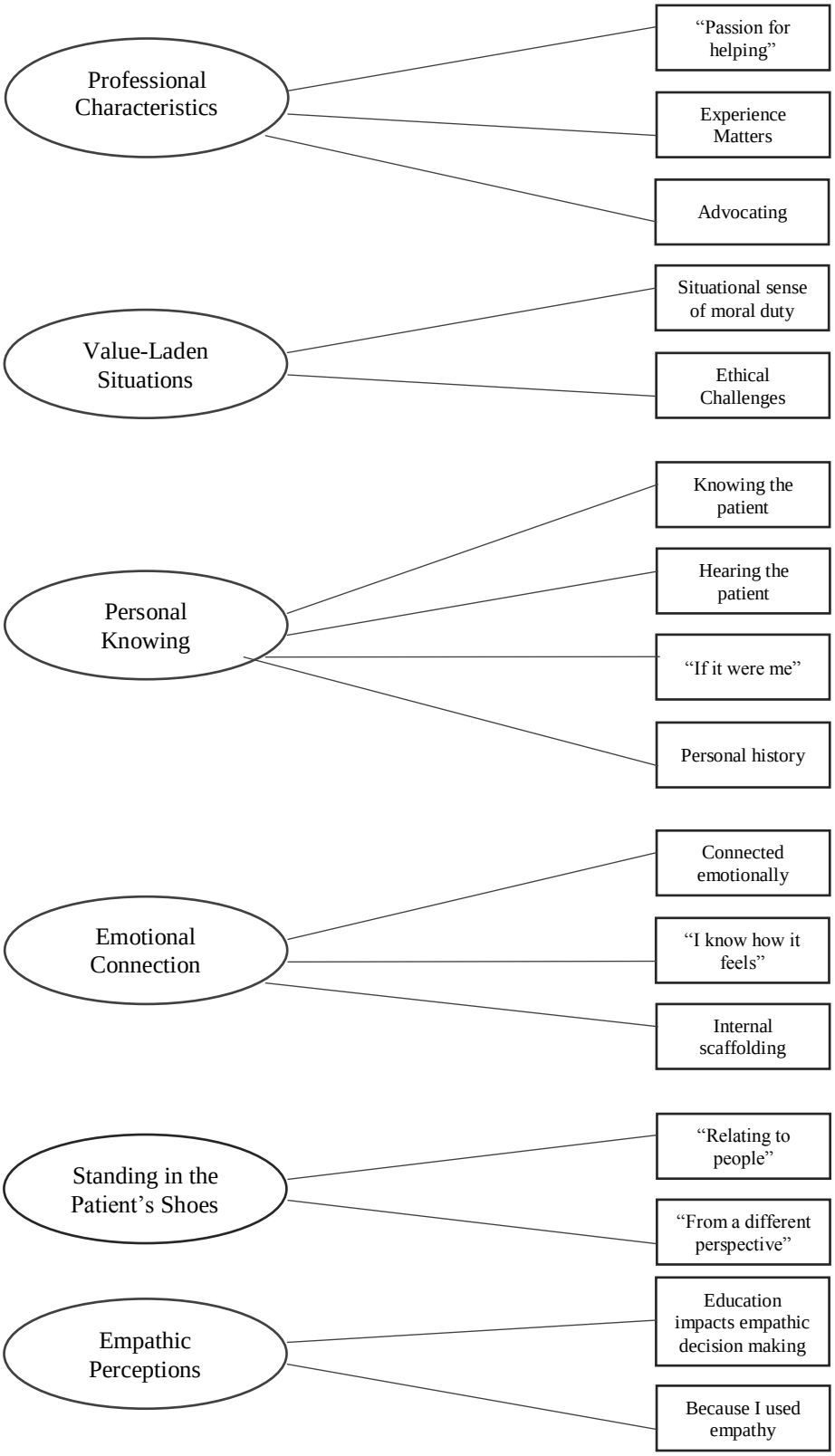

Figure 1. Code map second cycle codes and first cycle constituents.

APPENDIX D

UNIVERSITY OF ILLINOIS
AT CHICAGO

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

Approval Notice
Initial Review (Response to Modifications)

June 21, 2016

Sara Adams, MSN
Health Systems Science
845 South Damen
M/C 802
Chicago, IL 60612
Phone: (201) 920-1553 2

RE: **Protocol # 2016-0398**
"An Exploration of Humanities-Based Liberal Education Competencies and Empathic Decision Making in Baccalaureate Prepared Nurses"

Dear Ms. Adams:

Your Initial Review application (Response to Modifications) was reviewed and approved by the Expedited review process on June 21, 2016. You may now begin your research.

Please note the following information about your approved research protocol:

Please note that stamped and approved .pdfs of all recruitment and consent documents will be forwarded as an attachment to a separate email. OPRS/IRB no longer issues paper letters and stamped/approved documents, so it will be necessary to retain these emailed documents for your files for auditing purposes.

Protocol Approval Period: June 21, 2016 - June 21, 2017
Approved Subject Enrollment #: 200
Additional Determinations for Research Involving Minors: These determinations have not been made for this study since it has not been approved for enrollment of minors.
Performance Site: UIC
Sponsor: None
Research Protocol:

a) An Exploration of Humanities-Based Liberal Education Competencies and Empathic

Decision Making in Baccalaureate Prepared Nurses; Version 1; 04/11/2016

Recruitment Material:

a) Invitation emails will be used as consent documents

Informed Consents:

a) Initial Invitation to Participate; Version 3; 05/31/2016
b) Second Invitation to Participate; Version 3; 05/31/2016
c) Final Invitation to Participate; Version 3; 05/31/2016
d) A waiver of documentation (electronic consent/no written signature obtained) and an alteration of consent have been granted for this online survey under 45 CFR 46.117(c)(2) and 45 CFR 46.116(d) (minimal risk; subjects will be presented with an information sheet that includes the essential elements of consent)
e) A waiver of informed consent for access to emails of former students in student records for recruitment/contact purposes only with the written consent of the UIC Registrar has been granted under 45 CFR 46.116(d) (minimal risk)

Your research meets the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific category:

(7) Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please note the Review History of this submission:

Receipt Date	Submission Type	Review Process	Review Date	Review Action
04/12/2016	Initial Review	Expedited	04/20/2016	Modifications Required
05/03/2016	Response To Modifications	Expedited	05/16/2016	Modifications Required
06/01/2016	Response To Modifications	Expedited	06/21/2016	Approved

Please remember to:

→ Use your **research protocol number** (2016-0398) on any documents or correspondence with the IRB concerning your research protocol.

→ Review and comply with all requirements on the OPRS website under:
"**UIC Investigator Responsibilities, Protection of Human Research Subjects**"
(http://tigger.uic.edu/depts/ovcr/research/protocolreview/irb/policies/0924.pdf)

Please note that the UIC IRB has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your

research and the consent process.

Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 996-2014.

Sincerely,
Sandra Costello
Assistant Director, IRB # 2
Office for the Protection of Research Subjects

Please note that stamped and approved .pdfs of all recruitment and consent documents listed below will be forwarded as an attachment to a separate email. OPRS/IRB no longer issues paper letters and stamped/approved documents, so it will be necessary to retain these emailed documents for your files for auditing purposes.

Enclosures:

1. **Informed Consent Documents:**
   a) Initial Invitation to Participate; Version 3; 05/31/2016
   b) Final Invitation to Participate; Version 3; 05/31/2016
   c) Second Invitation to Participate; Version 3; 05/31/2016

cc: Lorna K. Finnegan, Health Systems Science, M/C 802
Linda Scott (faculty advisor), Health Systems Science, M/

Sara Adams MSN, RN

Curriculum Vitae

EDUCATION

University of Illinois at Chicago	PhD (expected 12/2016)
Valparaiso University, MSN- Nurse Educator	MSN 2009
Indiana University Northwest	BSN 1999

PROFESSIONAL EXPEREINCE

2012- present	Acting Assistant Professor/Adjunct Assistant Professor Indiana University Northwest, School of Nursing
2012- 2016	Teaching Assistant/Associate University of Illinois at Chicago, College of Nursing
2013-2013	Research Assistant, NCSBN National Simulation Study University of Illinois at Chicago, College of Nursing
2011-2013	Kaplan NCLEX Review Instructor Kaplan University
2008-2012	Adjunct Assistant Professor/Adjunct Instructor Valparaiso University, College of Nursing
2008-2009	Research Assistant, Health Visions Midwest Valparaiso University, College of Nursing
2000-2008	Staff Nurse, Oncology and Registry Ingalls Memorial Hospital
1998-2000	Staff Nurse, Oncology Community Healthcare System

HONORS AND AWARDS

2016 Daisy Award, University of Illinois at Chicago
2012 University of Illinois at Chicago, Jonas Scholar Award 2012-2014
2009 Valparaiso University, Graduate Faculty Academic Excellence Award
2009 Valparaiso University, Freda Scales Master of Science in Nursing Award

PRESENTATIONS

2016 Cancer: In Other Words: A Narrative Experience of Cancer, Indiana University Northwest
2014 Narrative Bridging, University of Illinois at Chicago- Brown Bag
2014 INACSL Simulation Guidelines: Practical Implications, Indiana University Northwest
2013 Creating a Tool-Kit to Advance Nursing Education, Jonas Scholar Conference

Washington D.C
2013 Creating a Tool-Kit to Advance Nursing Education, Illinois Organization of Nurse Leaders, Springfield, Illinois
2011 State of Healthcare in the United States, Universidad Vina del Mar, Vina del Mar, Chile

TEACHING EXPERIENCE

2014-2016	Didactic Instructor: NURS R375 Nursing Research for Evidence-Based Practice, NURS B234 Promoting Healthy Populations, NURS B261 Pathophysiology and Pharmacology
2013-2014	Didactic Instructor: NURS 365 Nursing Research, Clinical Practicum Instructor: NURS 345 Healthcare of the Adult 1, NURS 249 Fundamentals of Nursing
2012-2014	Teaching Assistant: NURS 202: Concepts and processes of Professional Nursing, NURS 397: Issues in Nursing Practice, NURS 403: Cultural Fluency, Communication, and Ethics
2012-2013	Clinical Practicum Instructor: Health Assessment, Fundamentals of Nursing
2009-2011	Didactic Instructor: Role of The Professional Nurse, Complex Needs of the Adult, Healthcare in Chile, Clinical Practicum Instructor, Health Assessment, Fundamentals of Nursing, Medical Surgical Nursing 2
2010	Guest Lecture: Gastrointestinal Issues in Adult Health

PROFESSIONAL ACTIVITIES

2014	Ad-hoc Reviewer, *Advances in Nursing Doctoral Education and Research*
2014	Service Learning Committee, Student Services Committee, Simulation Committee, Indiana University Northwest
2009-2011	Nursing Fellowship, Faculty Liaison, Sigma Theta Tau Zeta Epsilon Chapter, Vice President, Valparaiso University

PROFESSIONAL ORGANIZATION MEMBERSHIP

2014-2016	Midwest Nursing Research Society
2009-2016	National League for Nursing Member
2012-2014	American Nurses Association- Illinois
2012-2014	Illinois Healthcare Action Coalition- Education Workgroup
2009-	Sigma Theta Tau Nursing Honor Society 2009-2013 Zeta Epsilon Member 2014-present Alpha Member 2016- Alpha Chapter Campus Counselor

CERTIFICATIONS AND LICENSURE

Quality Matters Online Teaching Training Certification- 2016
Indiana University Online Teaching Certificate- 2015
Illinois Registered Nurse Licensure 1999- present
Indiana Registered Nurse Licensure 1999- present
Basic Cardiac Life Support Provider 1999- present