Therapeutic approach of nurses towards patients with the "do-not-resuscitate" directive in the intensive care unit and their family members

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ABSTRACT

Introduction: Nurses play a critical role in end-of-life care (EOLC), as they are always present at patients' bedsides and provide care and monitor their status. While providing EOLC, nurses must examine their actions and behaviors that may hinder patients from passing away peacefully and with dignity. The implementation of "do-not-resuscitate" (DNR) may present challenges for nurses, such as power conflicts, tension, and ethical dilemmas. The present study aimed to assess therapeutic approaches (empathy vs. sympathy) of nurses towards patients with the DNR directive in the intensive care unit (ICU) and their family members.

Methods: This cross-sectional study involved 128 nurses working in ICUs at a hospital in Saudi Arabia enrolled using a non-probability convenient sampling approach.

Results: During nursing care for patients and their families under DNR directive, ICU nurses exhibit greater sympathy (composite mean: 4.17; standard deviation [SD]: 0.84) than empathy (composite mean: 3.11; SD: 0.74). Meanwhile, no significant difference was observed in the empathy and sympathy levels of the nurses when grouped by demographics (p > 0.05). Notably, only empathy was important for nurses' educational certification (p = 0.0145, less than the significance threshold of 0.05).

Conclusion: Most ICU nurses exhibited sympathy more than empathy when caring for patients with the DNR directive and communicating with their family members. Nurses should prioritize empathy over sympathy or compassion when caring for patients and interacting with their family members in end-of-life circumstances. The findings of this study may guide the development of programs to improve nurses' therapeutic approaches during EOLC.

Keywords: sympathy, empathy, ICU nurses, end-of-life-care, therapeutic approach, caring

Introduction

Intensive care units primarily focus on critically ill patients, those requiring mechanical support, or those requiring monitoring because of the risk of life-threatening consequences over time. Nurses providing end-of-life care (EOLC) often engage with elements of love and tenderness, and their words hold significant power, shaping narratives and influencing perceptions while caring for patients on life support. Notably, some such statements may be useful, whereas others may be harmful to patients. End-of-life nurses caring for patients on their deathbeds and supporting their grieving families face significant emotional burden (Guerrero, 2019). Furthermore, ICU nurses may face concerns in communicating the "do-not-resuscitate" (DNR) directive to patients and their families, as this responsibility is outside their purview. Communication, as an aspect of compassionate care and articulation for care with respect to end-of-life issues in ICUs, is challenging, as nursing ICUs are designed for advanced and critical care (sensitive end-of-life issues) (Guerrero, 2019; Xia et al., 2020).

Empathy is defined as the ability to feel and understand feelings, wherein one tends to respond emotionally to another person's situation (Sinclair et al., 2017). In healthcare, sympathy or pity—reflected as feeling of sadness or discomfort due to another's loss—are less effective in promoting recovery and detrimental to nurse–patient relationship (Chaney, 2021). Training and practice elements may contribute to a decline in empathy among healthcare providers, thereby compromising patient care (Sinclair et al., 2017). Sympathetic nursing improves therapeutic results and is important for effective treatment (Maghsud et al., 2020). However, sympathy may lead to emotional involvement, resulting in a more impersonal approach to nursing (Hardy, 2019).

Training programs incorporating role-playing, case studies, and reflective practice can significantly enhance the ability of nurses to provide emotional support during critical moments. These programs can also serve as platforms for nurses to share their experiences and challenges, thereby promoting a culture of empathy and understanding within healthcare teams (Alsufyani et al., 2020). Additionally, trainings focusing on the emotional aspects of end-of-life decisions should be conducted to address the gaps in family-centered care. Such programs should emphasize the development of empathetic communication, active listening, and emotional support strategies. Healthcare institutions can improve the experience of patients and families by ensuring a more humane approach to EOLC, provided that practicing nurses are educated in these skills. The perspectives of the families of the patients regarding DNR should also be considered in elaborating the DNR directive, as this variable considerably influences EOLC (Schwartz et al., 2022). Healthcare workers must understand that providing care to patients extends to supporting families and that families experience emotional turmoil. Future studies should focus on establishing family dynamics in context with DNR decisions, and training programs for nurses should foster the development of supportive skills (Guerrero, 2019).

A clear gap remains in the existing literature, necessitating further exploration to systematically describe the family's experience with respect to DNR. Particularly, the emotions, agents, and their consequences should be investigated, and such insights would

assist in nursing and in understanding families and patients from a care perspective. The lack of research on this topic presents an opportunity for nursing practitioners to gain a deeper understanding of family dynamics during the final stages of nursing care. Nurses studying the interplay of empathy and sympathy with family decisions will be better skilled to manage the emotional tension experienced by families in such situations. (Tajari et al., 2018; Alsufyani et al., 2020). Therefore, this study aimed to evaluate therapeutic approaches of nurses towards patients with the DNR directive in the ICU and their family members, focusing on how nurses express empathy or sympathy with patients and their family members in the context of a standing DNR order.

Methods

Study Design

This cross-sectional descriptive study involved nurses caring for patients with a DNR directive.

Participants and Recruitment

The respondents in this study were ICU nurses of Dr. Soliman Fakeeh Hospital (DSFH) in Saudi Arabia, a pioneering health institution with landmark medical treatments and significant contributions since 1978. A total of 141 ICU nurses met the following inclusion criteria: 1) completed a diploma or bachelor's degree in nursing, 2) at least 6 months of ICU experience, and 3) Saudi or non-Saudi nationals. Nurses who did not meet the inclusion criteria were excluded. Of the total 141 nurses, 128 were enrolled in this study using a convenience nonprobability sampling approach, with a confidence level of 95% and an acceptable margin of error.

Research Instrument

The present study adopted a questionnaire "Nurses towards End-of-Life Situations: Sympathy vs. Empathy" from Guerrero (2019). This questionnaire comprises 12 closed-ended questions that evaluate therapeutic approaches of nurses, including eight and four questions related to empathy and sympathy, respectively, scored on a 5-point Likert scale. This tool has been validated by Guerrero (2019), reporting adequate internal consistency (empathy $\alpha = 0.728$; sympathy $\alpha = 0.804$).

Initially, we conducted a pilot study involving 40 ICU nurses to ensure the applicability of the tool to the respondents in this study. The reliability was assessed using Cronbach's alpha, obtaining internal consistency scores of 0.781 and 0.872 for the empathy- and sympathy-related questions, respectively. Notably, an α value of 0.73–0.95 indicates high reliability (Taber, 2018).

Data Collection Procedure

Data were collected from January 2023 to March 2023, following the approval from the Institutional Review Board of the study hospital. The researchers prepared a questionnaire and distributed it using an electronic Google Form, with the consent form attached

at the beginning, requiring respondents to read and agree to it before proceeding with the main questionnaire. Participants anonymity was ensured and protected throughout the study.

Prior to data collection, the researchers visited the ICUs and explained the purpose of the study to potential respondents. The respondents were selected with the help of ICU nurse managers. The Google Form link was provided to the available respondents during each visit, who took 10–15 min to complete the questionnaire. Respondents could ask questions to the researcher to clarify any concerns, thereby ensuring data quality. The researchers visited the site four times to achieve the recommended sample size.

Data analysis

SPSS Statistics 20 (IBM Corp., Armonk, NY, USA) was used to examine the data, following sorting. Descriptive statistics, including frequencies and percentages, were computed to summarize demographic information. A weighted mean method was used to assess the level of the therapeutic approaches of nurses (empathy vs. sympathy). Differences in empathy and sympathy according to demographic variables were evaluated using statistical analyses (t-test and analysis of variance). Data was interpreted based on the established ranges for empathy and sympathy levels (Table 1).

Table 1 Guide in interpreting empathy and sympathy levels of nurses

Range	Verbal interpretation per item	Overall verbal interpretation for empathy	Overall verbal interpretation for sympathy
1.00–1.49	Strongly disagree	Very low empathy	Very low sympathy
1.50–2.49	Disagree	Low empathy	Low sympathy
2.50–3.49	Neither	Moderate	Moderate
3.50–4.49	Agree	High empathy	High sympathy
4.50–5.00	Strongly agree	Very high empathy	Very high sympathy

Ethical considerations

Ethical approval was obtained from the Institutional Review Board of Fakeeh College for Medical Sciences and DSFH (approval no: 257/IRB/2022). Informed consent was obtained from the respondents after verifying their understanding of the study objectives, consequences, and voluntary participation.

Respondents were informed that they could withdraw from the study at any time. Confidentiality was maintained throughout the study, and personal identifiers were eliminated from the data, which were coded for analysis to ensure anonymity.

Results

Table 2 presents the demographic characteristics of the nurses. Notably, 6.25% and 93.75% of the respondents were males and females, respectively, with 51.56% aged 30–40 years. Furthermore, most of the nurses had a bachelor's degree in nursing (92.97%) with 3–6 years of clinical experience (33.59%).

Table 2

Demographic characteristics of the respondents

Demographic characteristics	Frequency (f)	Percentage (%)
Sex		
Male	8	6.25
Female	120	93.75
Age		
20–30 years	52	40.63
30–40 years	66	51.56
40–50 years	10	7.81
Educational qualification		
Diploma in nursing	6	4.69
Bachelor's degree in nursing	119	92.97
Master's degree in nursing	3	2.34
Clinical experience in the ICU		
<2 years	27	21.09
3–6 years	43	33.59
7–9 years	27	21.09
≥10 years	31	24.22

Table 3 presents levels of therapeutic approaches (empathy vs sympathy) of ICU nurses towards patients with the DNR directive and their family members. The mean value was the highest for the empathy item "I can often understand how a patient or his/her relative is feeling even before he/she tells me" (mean: 4.02; SD: 0.93). Conversely, the lowest mean value was observed for the item "When a patient or his/her relative is angry, I feel angry too" (mean: 2.13; SD: 1.28), indicating disagreement of the respondents. The composite mean for empathy was 3.11 with a SD of 0.74, interpreted as a moderately used approach by ICU nurses caring for patients with the DNR directive and their family members.

The mean value was the highest for the sympathy item "I feel sorry for a patient who has just been informed that he/she has a terminal illness" (mean: 4.27; SD: 1.00). Conversely, the lowest mean value was observed for the item "I am concerned for relatives of patients with terminal illness" (mean: 4.02; SD: 1.04), indicating disagreement of the respondents. The composite mean for sympathy was 4.17 with an SD of 0.84, interpreted as a highly used approach by ICU nurses caring for patients with the DNR directive and their family members. Collectively, these findings indicate that ICU nurses exhibited a higher degree of sympathy than empathy while caring for patients with the DNR directive and their family members.

Table 3

Levels of therapeutic approaches (empathy vs. sympathy) among ICU nurses

No.	Indicator	Mean	SD	Verbal interpretation
1.	"When a patient or his/her relative is anxious, I become anxious too."	2.57	1.36	Neither
2.	"When a patient or his/her relative is angry, I feel angry too."	2.13	1.28	Disagree
3.	"When a patient or his/her relative is scared, I feel afraid."	2.18	1.24	Disagree
4.	"When a patient or his/her relative is sad, I become sad too."	3.04	1.24	Neither
5.	"I can often understand how a patient or his/her relative is feeling even before he/she tells me."	4.02	0.93	Agree
6.	"I can tell when a patient or his/her relative acts happy when he/she actually is not."	3.64	1.03	Agree
7.	"I can easily tell how a patient or his/her relative is feeling."	3.59	1.02	Agree
8.	"I can tell when a patient or his/her relative is angry even if he/she tries to hide it."	3.68	1.08	Agree

	Empathy composite mean	**3.11**	**0.74**	**Moderate empathy**
9.	"I am concerned for relatives of patients with terminal illness."	4.02	1.04	Agree
10.	"I feel concerned for patients who have a terminal illness."	4.16	0.99	Agree
11.	"I am sorry for a patient or his/her relative who feels sad."	4.22	0.86	Agree
12.	"I feel sorry for a patient who has just been informed that he/she has a terminal illness."	4.27	1.00	Agree
	Sympathy composite mean	**4.17**	**0.84**	**High sympathy**

Table 4 presents the differences in the empathy levels of nurses grouped according to their demographic characteristics. The Pr ($|T| > |t|$) and Prob > F values were higher than the 0.05 threshold of significance for sex, age, and years of clinical experience. Therefore, no significant differences were observed in the level of empathy among nurses across their demographic profiles. However, a difference was observed in their educational qualification, with an F value of 1.27 and a Prob > F value of 0.0145, which is less than 0.05 significance level.

Table 4

Differences in the empathy levels among nurses grouped according to their demographic characteristics

Demographic characteristics (t-test)	Mean difference	Pr ($|T| > |t|$)
Sex	0.236	0.3808

Demographic characteristics (analysis of variance)	F	Prob > F
Age	1.27	0.2854
Educational qualification	1.27	0.0145
Clinical experience in the ICU	2.37	0.0979

Table 5 presents the differences in sympathy levels among nurses grouped according to their demographic characteristics. The Pr ($|T| > |t|$) and Prob > F values were higher than the 0.05 threshold of significance for sex, age, years of clinical experience, and educational qualification. Therefore, sympathy levels did not vary significantly among nurses across their demographic profiles.

Table 5

Differences in the sympathy levels among nurses grouped according to their demographic characteristics

Demographic characteristics (t-test)	Mean difference	Pr ($|T| > |t|$)
Sex	0.289	0.3473
Demographic characteristics (analysis of variance)	**F**	**Prob > F**
Age	2.37	0.0979
Educational qualification	0.59	0.5563
Clinical experience in the ICU	1.51	0.2149

Discussion

This study evaluated therapeutic approaches (empathy vs. sympathy) of nurses towards patients with the DNR directive in the ICU and their family members. ICU nurses exhibited greater sympathy than empathy while caring for patients with DNR directives and communicating with their family members. Furthermore, no significant differences were observed in empathy levels of nurses based on their demographic characteristics (sex, age, and years of clinical experience), except for their educational qualification. Meanwhile, no differences in sympathy levels were observed among ICU nurses based on their demographic characteristics.

Although the healthcare system endorses the value of empathy and performative training for nurses, some do not view such oversimplified sympathetic gestures as nontherapeutic. Notably, such responses, rooted in sympathy, are usually not needed by most patients. Furthermore, nurses tend to confuse between sympathy and empathy, leading to the conflation of these two fundamentally different concepts. Nevertheless, the present study revealed that the ICU nurses felt sympathy rather than empathy for patients with the DNR directive and their family members during nursing care. Nurses play a significant role in providing end-of-life services to patients and encounter emotional situations while performing their roles. Some nurses struggle to part with their patients because of the

emotional bond, feeling that they had no alternative. Rickerson (2005) and Guerrero (2019) reported that professional nurses are most affected by the loss of their patients, and subsequent loss-associated grief symptoms, including sadness, crying, and thoughts related to death, can negatively affect their social relationships, including those in the workplace (Guerrero, 2019).

In psychology, empathy is usually distinguished from sympathy and personal distress. Batson and Coke (1983) define empathy—also referred to by the synonym "empathic concern"—as "an emotion whose expression is caused by the feeling of concern for another individual." However, unlike empathy, sympathy relates with a person without adopting their emotions (Lennon and Eisenberg, 1987). Personal distress is defined as the feeling of self-pain, self-hate, or uneasiness relative to other people's suffering. Personal distress is less likely to promote altruistic behavior, as it is self-oriented rather than other-oriented (Lennon and Eisenberg, 1987). Mogadasian et al. (2014), unlike our study, reported adequate empathetic levels among nurses towards patients with an average of 38.8%. Furthermore, a significant association was observed between the respect nurses showed towards patients' families and empathy. Moreover, developing empathy among nurses could help address the expectations of patients' family members. Nurses can encourage family members to engage in treatment planning for the patients by empathic communication. However, further research is imperative to substantiate these findings.

Empathic relationships between nurses and patients can improve clinical effectiveness (Wu, 2021). Norman (1996) claimed that compassion helps in caring for older patients with mental disorders. Reynolds and Scott (2000) reported that an empathetic stance in nursing can result in a range of beneficial patient responses, such as increased pulse rate, pain reduction, and emotional ventilation. Furthermore, empathy in nursing significantly improves the self-concept of older patients (Williams, 1992). La Monica et al. (1987) showed that empathy among nurses could effectively relieve anxiety, depression, and aggression in patients with cancer.

Unlike sympathy, which is limited, empathy encompasses broader and more intense compassion for the situation of another person. In empathy, individuals themselves elicit the emotions of the other, and this is the primary difference between the two concepts. Sympathy simply involves being in the same state as another person, whereas empathy involves the ability to sense and understand another person. Hence, as defined by Kramer (2018), empathy is the ability of a person to feel the emotions of another person by seeing and feeling from their perspective. Strong interpersonal bonds can be developed by incorporating empathy into nursing practice. However, literature on how such empathy develops through conversations between nurses and patients remains limited. Jones (2003) cautioned that conversation analysis may be too technical to capture the role of each participant in a nurse–patient interaction. From the qualitative perspective of interaction analysis, empathy can be considered as an action that a person performs in a social context (Heritage & Watson, 1979). According to Wu (2021), the analysis of conversations and their social context in nursing practice could be a significant aspect in understanding the concept of empathy. Conversation analysis can further be used to classify and examine four types of interactive sequences of empathic engagement. Furthermore, Wu (2021) reported

that "empathy" promotes a warm interactional ambiance, enabling nurses to understand patients' conditions and see things from the patient's perspective. Our study indicates that empathy, to a certain degree, is an umbrella phenomenon that allows justification for the logical flow of events and enhances the outcomes of nursing practice. These universality principles illustrate the key sequences of exemplary nurse–patient interactions that are intimate yet non-demanding. Frontline data could potentially provide critical information that would be useful for developing the competencies of clinical nurses further in practice.

Conversation analysis presents a new opportunity to observe and understand complex nurse–patient relationships. Caregiving processes and actual interactional episodes during nursing care are sequentially specified in the context of the nurse-patient relationship. Furthermore, both nurses and patients can independently and together co-construct conversation turn-taking exchanges in real-time, promoting empathy (Mayor & Bietti, 2017). Moreover, conversational analysis provides an opportunity to identify how empathy is developed during communication between a nurse and a patient (Macdonald, 2016).

Several empathic barriers exist, along with ways to transcend them. These barriers include (i) not paying attention to any client, (ii) being able to empathize with the other person's feelings but not knowing how and who to communicate with, and (iii) not feeling what the other person feels but recognizing that their feelings are important and should be addressed. Such barriers can be addressed through the following steps: improving body language, understanding depth in voice, minimizing distractions while communicating with the client, and recognizing that disagreeing with a person while understanding their feelings and causes of their actions is possible (Swink, 2018). Several researchers, including Wilkinson (1991) and Booth (1999), have documented that some nurses worry about their relationships with patients because they feel that they do not have good communication skills. Consequently, they may resort to actions that are detrimental to their ability to communicate with patients. Furthermore, some nurses remain hesitant about helping patients with particular feelings or opinions because of their poor education and lack of information. Subsequently, they further resort to the communication barrier, avoiding discussing the psychological topics of the patients. Empathy is a crucial element of nursing practice. However, practitioners often exhibit low or moderate levels of emotion. Kahriman et al. (2016) reported that nurses should focus on improving specific areas of their practice, including communication and empathy, while providing care.

Study Scope and Limitations

As this study was limited to ICU nurses at a single hospital, the generalizability of the findings may be limited by its homogeneity and convenience sampling approach. Furthermore, generalizability of the results may be limited by a small sample size and bias associated with non-probability sampling. Nevertheless, the methodology used in this present study facilitates an in-depth understanding of the perception of ICU nurses towards patients with the DNR directive and their family members. Furthermore, the ethical methodology using standard research tools followed in this study provides an insightful understanding of patient–nurse interactions in ICUs in this context.

Conclusion

The findings of the present study revealed that most nurses working in ICUs tend to express greater sympathy than empathy towards patients with the DNR directive and their families while nursing.

However, nurses should demonstrate greater empathy than sympathy while providing palliative and EOLC care for patients and interacting with their families during such critical times. The results of this study may guide the development of strategies to enhance nursing care for patients in their last stages of life.

Recommendations

Similar multi-center studies with larger sample sizes within private and government tertiary hospitals in Saudi Arabia should be conducted. Furthermore, comprehensive research on the effects of empathy and sympathy during palliative care and EOLC is essential. Additionally, conducting lectures, trainings, workshops, and simulations as part of professional development activities for nurses, focused on responding to situations such as providing support to patients and family members during palliative care and EOLC, could be beneficial for improving nursing quality and ensuring safe patient care.

Availability of data statement

The data generated in this study are available from the corresponding author upon request.

Declarations

Ethics Approval Statement and Consent to Participate

Ethical approval was obtained from the Institutional Review Board of Fakeeh College for Medical Sciences and DSFH (approval no: 257/IRB/2022). Informed consent was obtained from each participant before participation in the study. All the research procedures were performed in accordance with the Declaration of Helsinki.

Declaration of Conflicting Interests

The authors declare that they have no competing interests.

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