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# Nurse-Patient Conflict: Verification of Structural Model

Mayumi Uno

## Abstract

This chapter focuses on the overlooked area of everyday nursing care in which engaging in the depressive feelings between nurses and patients is not recognized as part of nursing care. To comprehend situations that had been overlooked, a conceptual model was constructed by focusing on nurse-patient conflicts and understanding the perception of both nurses and patients based on phenomena. In the established model, it is considered that the so-called “passion” emanating from one’s personality, which is beyond techniques of communication and empathic understanding, is involved; this passion is expressed as an “emotional exchange.” In an “emotional exchange,” one sends “emotional” messages to whom he/she feels safe to express “emotions” and shares similar emotional world by receiving those “emotional” messages as they are. Such an expression has not been reported previously.

**Keywords:** nurse-patient relationship, conflict, structural model

## 1. What is a service

A service is characterized by “intangibles,” “simultaneity of production and consumption,” “equivalent importance of the results and process” and “co-production with customers.” The types of services include “core service,” which is at the core of a service product, “sub-service,” which is associated with the core service, “contingent service,” which adapts to the situation, and “potential service element,” which is sought out by customers [1]. Subservice, which does not reflect on customer service at hotels and costs at hospitals, tends to be emphasized in service quality evaluation more so than the core service, including the provision of technology that reflects on costs [2]. Quality service is dependent on the subjective and objective evaluation of customers. Customer satisfaction with regard to service is associated with emotion, which impacts evaluation over time [3]. According to Simomura [4], emotion is a central concept in consumption behavior, and satisfaction with a service and customers’ emotions cannot be discussed separately. With respect to customer demand and quality, good quality as perceived by a customer is meeting the customer’s demand [5], as well as having a certain level of high knowledge, sensitivity, and values to create a better service [6].

## 2. Services measured using customer expectations and satisfaction

Parasuraman et al.’s [7] SERVQUAL Instrument (a Multiple-item Scale for Measuring Service Quality) is most widely used for measuring a service based

on the difference between expectations and satisfaction [8]. This instrument can measure not only customer expectations but also their perception of the quality of service that they received [9]. The perception of quality by service recipients is associated with the morale of the service providers and corporate spirit [10, 11]. We must know and understand the expectations of patients to measure quality of health care. In service marketing research, the relation between expectations for a service and perception of the service received is drawing attention [7, 10, 12–14]. Parasuraman et al. [15] evaluated SERVQUAL Instrument (a Multiple-item Scale for Measuring Service Quality), which they reported in 1985, based on psychological diagnosis. Accordingly, SERVQUAL for patient satisfaction with nursing care, namely, SERVQUAL-N, which is a modified version of SERVQUAL for nursing care, was developed [16]. Consequently, service evaluation based on SERVQUAL has been conducted in Europe, North America, and Asia [17–22]. In SERVQUAL, service quality comprises elements of reliability, responsiveness, assurance, empathy, and tangibles. Meanwhile, Shanaki et al. [23] described the effects of empathy toward service quality using tangibles, responsiveness, trust, accessibility, and service recovery. This shows continuous development in research in various academic fields.

### **3. Focusing on nurse-patient conflict**

A nurse must perceive the feelings and emotions of a patient and respond appropriately so that the latter recognizes that he/she is receiving high quality health care. Nurse-patient conflict arises when a patient's expectations are not met and trust is not established. It is ideal for the conflict to be resolved between a nurse and a patient. Patients have feelings that they are not able to tell nurses about, from which a potential conflict can arise. Patients suffer in situations where they perceive conflict, but they are unable to bring it up with the nurses because of reluctance or resignation. Because a patient's perception affects quality evaluation of nursing care, this study focused on nurse-patient conflict and found meaning in understanding nurses' and patients' perception of phenomena. In the field of nursing care, consideration of patients' emotions and response to their feelings have been considered important. To improve quality of nursing care, nurses are required to go beyond the superficial interaction with patients and respond in a way that is backed by academic significance. Patients' evaluation is indispensable to quality nursing care. There is sufficient need for recognizing the fact that patients carry chaotic feelings, which, in turn, must be comprehended to be able to verbalize, document, conceptualize, and generalize such phenomenon. Therefore, this study is significant in that it academically focused on a phenomenon that has been overlooked thus far.

## **4. Literature review**

### **4.1 Medical and nursing services and patient satisfaction**

In general, various elements, including technical factors, interpersonal factors, cost, and environmental factors, influence patient satisfaction. As such, measuring patient satisfaction in diverse scenes of nursing care is a complex task [24–27]. Patient satisfaction is recognized as an important index for service quality [19, 28, 29]. There is a positive correlation between patient satisfaction regarding nursing care and a patient's perception of service quality [30]. There is also a strong correlation between satisfaction with nursing care and general satisfaction [31]. All

nursing care activities are associated with a patient's perception of patient satisfaction [32]. Moreover, values regarding patient satisfaction continue to evolve with time [33]. Oxler [34] focused on patient dissatisfaction and reported that commitment on the part of top leaders and staff was required to set aside time for understanding patient needs, thereby resolving complaints from patients and enhancing satisfaction.

#### **4.2 Development of a measurement scale for patient satisfaction and a conceptual model in nursing care**

In a study on patient satisfaction in nursing care, Abdellah and Levine [35] reported on patient satisfaction and occupational satisfaction of nurses. Risser [36] developed the Patient Satisfaction Scale (PSS) for measuring patient satisfaction with primary care nurses and nursing care. Research has advanced, starting with the analysis of the "patient satisfaction" concept regarding modern nursing care [37], incorporation of outpatients' perception into the definition of nursing quality, demonstration of a NEdSERV quality model and development of a scale for service quality in nursing education [38]. These research activities led to the development of a patient-oriented scale for measuring service quality in the outpatient department [39]. In a survey conducted with patients awaiting discharge from the surgical ward of a teaching hospital in Taiwan, a primary care nurse's years of experience as a nurse was found to have affected patient satisfaction [40]. Studies have reported the necessity of an examination focusing on new care models, a partnership care delivery model/core concepts and new models [41], an analysis of patient satisfaction with nursing care using a conceptual nursing framework [33], the development of a satisfaction scale for local nursing care [42], a gap model of care quality in patient-centered nursing care for elucidating concepts of patient-centered care [43], and the development of a scale for measuring satisfaction of critically ill patients [44].

#### **4.3 Nurse-patient relationship**

Henderson [45] described her way of understating patients as "getting inside his/her skin," and indicated that nurses should discern the needs of patients before providing nursing care. In the beginning of *Interpersonal Aspects of Nursing* by Travelbee (1971), Ruth Johnston's (*American Journal of Nursing* 1971) "Listen, Nurse" was used to emphasize the interpersonal relation that transcends the positions of a nurse and patient. Peplau [46] demonstrated the importance in the encounter between a nurse and a patient and reported that a moral encounter that conveys the understanding of a patient's vulnerability is important. Watson [47] showed that the nurse-patient relationship in nursing science contains intersubjective care and that its practice and process become transpersonal and metaphysical. Reported that a closer relationship is established between a nurse and a patient by shifting the nursing care perspective from organizational goals to patient-centered care (PCC). Cignel [48] considered compassion as an important concept in nurse-patient relationship and argued that compassion as the answer to suffering, which is at the center of care, is equivalent to high-quality care in today's medical care. Described the influence of nurse-patient relationship by stating that the technique used by nurses to draw resources in managing patients, by involving themselves in a patient's phenomenon and distancing themselves, attenuate their suffering that have become involved, but it may keep them from using resources and possibilities gained through interaction with patients. Stated that there is an interrelation within a social relationship, which is characterized by a complementary relationship



through self-care based on an existing contractual relationship; Orem said that an ideal relationship would be one in which a patient's and his/her family's stress is reduced and would help them manage matters related to health and health care with a sense of responsibility.

#### **4.4 Trust between nurses and patients**

High-quality nursing care is based on trust between nurses and patients. The word "trust" is derived from an old term used to express fidelity and loyalty; this fact has a long history [49]. It is difficult to clearly define nurse-patient trust based on literature [50–52]. Reported that a patient's trust in a nurse is a necessary element for establishing a connection between the patient and that nurse.

Despite the lack of a clear definition of trust, trust affects whether a patient accepts care and treatment [53–55] and is an important factor in a nurse-patient relationship [51, 56]. Johns [57] suggested medical benefits, vulnerability, dependency, and participation in a care plan as being part of a conceptual framework of nurse-patient trust. Meanwhile, Belcher [58] stated that nurses need to act as good communicators to establish a close relationship with a patient while building trust.

#### **4.5 Transition of the concepts of nursing quality until the 2000s and universality**

In the 1950s, various nursing theories by nursing theorists were published in countries, including the United States. Starting with "Interpersonal relations in nursing" by Peplau [59] and the "Textbook of the principles and practice of nursing" by Harmer and Henderson [60], Johnson [61] argued that nursing requires care that must be provided by nurses to patients. Subsequently, nursing was considered as being based on interpersonal and personal relationships [62, 63]. As a result, mutual relationship drew attention. After Meyeroff's [64] report on caring was published, caring drew attention in the 1970s. Human caring has been referred as concern and respect for others [65]. Considered caring as the heart and soul of nursing from the viewpoint of the diversity and universality of cultural care. Watson [47] placed nursing in relation to metaphysics and indicated that care is the essence of nursing; she also noted that caring is able to utilize humanity as common sense in intersubjective interaction as defined by phenomenology while suggesting an interrelationship between souls. Based on theorists' conceptual analyses of caring, Morse et al. [66] classified caring into the following five categories: (1) caring as a human state (Lininger et al.), (2) caring as an affect (Babes), (3) caring as a moral imperative or ideal (Watson et al.), (4) caring as an interpersonal relationship (Gardo et al.), and (5) caring as a nursing intervention (Brown et al.). Therefore, in the 1960s and the 1970s, the nomenclature of primary phenomena in nursing science was established because of the clear need for detaching nursing from practice based on medical models [45, 67, 68]; (Rogers, 1970). Nursing concepts in Japan have been affected by claims of theorists who underwent these changes. The theory of human caring became widely known in Japan when Watson visited the country around 1990. Human care, whose main focus is on transpersonal care, has a high affinity with the spiritual culture of the East, and it appears to have been accepted as the essence of universal nursing care.

#### **4.6 Transition of the concepts of nursing quality in recent years and universality**

Around 2000, the importance of evidence-based practice (EBP) for high quality nursing was emphasized. It was defined as an important perspective for nurses when taking action as a professional [69–72]. Sackett et al. [71] pointed out that

EBP did not contain the opinions and decision-making of patients along with scientific evidence.

Patient centered care (PCC), along with nurse-patient relationship, was considered the basis for nursing care. PCC drew universal attention as being a form of active nursing intervention including sympathy and empathy [73–75]. Sidani [76] defined PCC as the provision of excellent service and improvement of quality patient care. Meanwhile, the Agency for Healthcare Research and Quality (AHRQ 2001) stated that placing an emphasis on PCC improves the quality of interaction between patients and health care providers and empowers patients in the process. EBP and PCC do not conflict one another and should not be considered separately. Burman [77] emphasized that EBP is among the cornerstones for providing better nursing care to patients. Burman also noted that the integration of EBP and PCC is essential for the health management of patients and the cultivation of organizational culture by nurses and other highly motivated clinicians to provide interdisciplinary PCC is required.

#### **4.7 Empathy**

The term empathy was used by Robert Vischer, a German psychologist, in 1873. It was derived from the German word *Einfühlung*. It was born from the esthetics of the time, which belonged to psychology that considered the empirical/aesthetical/psychological aspects as important [78]. Empathy is the ability to share others' thoughts and emotions [79]. It facilitates proactive behavior toward others and promotes social interaction as well as tolerant relationships. It is cultivated through time-dependent change as a person undergoes the developmental process. This ability appears in early childhood, develops in complex form from school age to adolescence (Eisenberg et al., 2002) [80], and continues from adulthood to old age [81, 82]. Empathy training facilitates the development of emotional abilities in school-age children, promotes skills and friendship [83], and enhances social conduct in adulthood [84]. The concept of empathy includes cognitive empathy, which allows one to sense the emotions of others and enables intentional thinking to a certain extent, and emotional empathy, which is accompanied by physical responses that are difficult to intentionally control [85, 86]. Gutsell and Inzlicht [87] described empathy from three perspectives: behavioral empathy, physical empathy, and subjective empathy.

#### **4.8 Empathy in nursing**

Research on empathy has a long history in disciplines, such as psychology and sociology. In nursing science, research has been conducted based on these academic backgrounds. Empathy has been considered as a primary basic concept in nurse-patient relationships and nursing practice. Ens [88] defined empathy as a complex part of the concept of countertransference, whereas Roger [89] argued that countertransference is an inevitable factor in a nurse-patient relationship. Scott [90] maintained that empathy is based on moral perception. Empathy is said to be a technique developed for counseling in the field of psychology [91]. However, Nightingale had used "sympathy" to refer to nurse-patient relationships before the term empathy was used. The reasoning that "nurses must be kind and sympathetic at all times, but they should never be emotional" is based on the recognition that this quality as a nurse assists the treatment process in a nurse-patient relationship [59]. Olso [92] found that there was a correlation between empathy shown by nurses and quality of nursing care. Erikson [93] defined empathy as the ability to show concern for suffering and demonstrated that nurses are required to perceive

the suffering of patients so that the latter are able to feel their human dignity being maintained. Erikson [94] stated that nurses must find the desires, trust, hope, powerlessness, guilt, and shame of patients to alleviate the latter's suffering and must understand each patient's unique experience with, knowledge of, and way of feeling toward his/her disease [93, 95]. Hence, empathy can be said to be the basis of therapeutic relationships in nurse-patient relationships.

#### **4.9 What is suffering**

Suffering refers to feelings and emotions necessary for those with disease, disability, and life issues to live, which form their experiences. For instance, this includes a diagnosis before birth made possible with medical advances, congenital disorders, chronic diseases, mental illnesses, and situations in which death is impending [63, 96]. According to Frankl [97], who is a psychiatrist heavily influenced by Freud and Adler, suffering is not something that one is born with but rather something one acquires. This is expressed as the "ability to suffer" and some consider that suffering cannot even be acquired if one is emotionless. Travelbee [63] stated that suffering, as with a disease, is an everyday life experience that befalls anyone and defines a status where an individual encounters suffering and experiences suffering at its worst as a malignant phase of despair non-caring and the terminal phase of apathetic indifference. Kato (2004) described suffering from a philosophical/ethical standpoint as primary and secondary suffering. Primary suffering is the anguish/suffering of those that seek help, whereas secondary suffering is suffering caused by a lack of response, inappropriate response, or failure/injustice/malice inherent in the action of responding.

#### **4.10 Patient's suffering and nurse's caring**

Travelbee [63] suggested that suffering is accompanied by caring, that vulnerability to suffering is related to the ability range and depth of caring, and that the lack of caring ability induces strong suffering. This means that nurses attempt to truly understand the experiences and feelings unique to a patient [93, 95]. Mayeroff [98] stated that caring practice is formed when those involved share time and place by "being together" and "living together," and emphasized the continuous relationship between the two. Ukigaya [99] indicated that nurses are also cared for by patients and that care has a bi-directional effect. Studies on patients' suffering and nursing care must show that nurses are prepared to identify the suffering of patients for them to feel that their dignity is honored.

Various studies on critical life situations, mental problems, and end-of-life suffering have been conducted. However, no study focuses on patients' emotions (secondary suffering) and shows that nursing (service) is no other than engaging with them.

#### **4.11 Conflict research and its transition**

Conflict research has long been conducted in the fields of, among others, psychology and sociology. Robbins [100] defined conflict as a process that starts when one perceives that others have exerted or are attempting to exert a negative effect on matters he/she considers important. No other problems are as strongly connected to emotion as when a conflict arises in interpersonal relationships and emotional changes accompany the occurrence of a conflict. In other words, Robbins stated that conflicts cannot be resolved effectively if one disregards the emotional element of a conflict and attempts to resolve them based on rationality and logic.

#### **4.12 Conflict research in medical care and nursing**

Marquis and Huston [101] defined conflict as arising from differences in values, expectations, and backgrounds. They suggested that “cultivation of a mutual relationship and sharing of understanding” are required for patients and medical professionals to maintain a positive relationship. They and stated that conflict arises when the personal relationship is no longer smoothly maintained [102]. Reports on patients’ specific situations, difficult patients [103], acute psychiatric wards [104], comparison of home care and nursing homes for older adults [105], and ways to respond to a conflict in specific scenes have been published in clinical conflict research since 2005. Nurses tend to use mutual dialog instead of engaging in a conflict in a stern manner to resolve conflicts in nursing situations [106]. Nurse-patient relationship is fundamental in partnership in nursing and interaction is required to maintain a positive relationship [107].

#### **4.13 Definition of terms**

Conflict: In this study, conflict does not refer to evidential conflicts (e.g., medical disputes), but rather to nurse-patient mood discrepancies and emotions.

#### **4.14 Ethical considerations**

We explained to all eligible participants that the data obtained in this study would not be used to identify any individuals or used outside of this study; further, it would be strictly managed and destroyed upon completion of the study.

Furthermore, we explained to the nurses that participation was voluntary, refusal to participate would not be disadvantageous to them in any way, participation had no relationship with their course evaluation, and we would consider their submission of the survey form as their having consented to participate.

By contrast, in our explanation to the phone counselors, we assured them that participation in the interview was voluntary, had no relationship with their company performance evaluation, and they could rescind their consent to participate at any time. We obtained permission to use the existing data from the copyright holders.

This study was conducted under the approval of our institution’s research ethics committee.

### **5. Related research history and the position of the present study**

As shown in the literature review, when a person makes some kind of value judgment, the emotion associated with the service received rather than the actual service received or the fact that he/she received the service affects the evaluation. Customer response to a service has been researched and systematized in business administration as direct purchasing and consumer choice behaviors. In the medical field, efforts have been made to adapt customer satisfaction and consumer choice behavior, which have been systematized in business administration, to clinical practice.

The focus of the present study is everyday nursing settings in which patients are in a specific (non-critical) situation. A patient suffers when he/she senses that a nurse regards his/her existential value lightly. A patient’s anguish/suffering constitutes primary suffering; secondary suffering is caused by a nurse’s lack of response to the primary suffering or a nurse’s inappropriate response or when failure/injustice/malice is inherent in a nurse’s action of responding. In the present



study, I focused on nurse-patient conflict to understand patients' suffering and nurses' and patients' perception of suffering. The reason this study focused on conflict is that a conflict is caused by emotional differences resulting from changes in the nurse-patient relationship. There is no study that focuses on the perception of patients, who are the service receivers, and bi-directionally examines the perception of nurses and patients with a focus on the sensing of emotional fluctuations and thoughts. Therefore, in this study, patients' unspoken thoughts were verbalized and a conceptual model for phenomena, which have been overlooked by focusing on nurse-patient conflict in medical treatment settings, was constructed.

## **6. Conceptual framework of the study**

Stages 1–4 of Robbins' [100] framework for the conflict process was applied as follows to nurse-patient conflicts in nursing settings where patients' status was non-critical.

Stage 1 (potential opposition): elements latent in the occurrence of a conflict.

Stage 2 (cognition and personalization): scenes in which a conflict occurs  
<Recognition>.

Stage 3 (behavior): response (in expectation of problems).

Stage 4 (outcomes): outcomes (of a successfully maintained/built positive relationship).

## **7. Purpose of the study**

The present study focused on areas that have been overlooked in everyday nursing scenes in which engaging with the depressing feelings of patients arising in nurse-patient relationships is not recognized as nursing. To understand the circumstances that have been overlooked, the present study focused on nurse-patient conflict and aimed to understand phenomena from the perspective of both nurses and patients and to establish a conceptual model.

## **8. Research methods**

### **8.1 Survey participants**

#### **1. Nurses**

For a descriptive survey on nurses, this study involved 320 nurses that participated in a nursing manager workshop organized by a local nursing professional association in Japan. The reason for the selection was that they had gained appropriate nursing experience as a manager and that their experiences could be verbalized.

#### **2. Telephone counselors (patients' end)**

For a survey on patients, because it was difficult to obtain data by interviewing patients directly in line with the intent of the present study, we interviewed eight telephone counselors. Telephone counselors belong to an incorporated non-profit organization whose members comprise non-medical professionals located in Osaka Prefecture, Japan. The organization provides consultations geared toward people for patients with feelings that they were not able to convey to medical professionals.

## 8.2 Survey process

### 1. Nurses

In the descriptive survey on nurses, they were instructed to recall nurse-patient conflicts and describe them. Age and years of nursing experience at the time of conflict were recorded as personal characteristics.

### 2. Telephone counselors (patients)

In the interviews with telephone counselors, they were instructed to recall consultations regarding nurse-patient conflicts. It was confirmed that existing data could be organized in a similar structure to data obtained through the interviews. With regard to personal characteristics, we referred to the age (age range) of patients who called in for a consultation and telephone counseling history of the telephone counselors.

## 9. Data obtained

In the descriptive survey on nurses, 72 scenes were subjected to analysis after 72 scenes were collected and evaluated to determine whether they were in line with the intent of the present study. In the interviews with telephone counselors, verbatim records of all the interviews were made, and 72 scenes were subjected to analysis.

## 10. Results

### 10.1 Gap in perception between nurses and patients

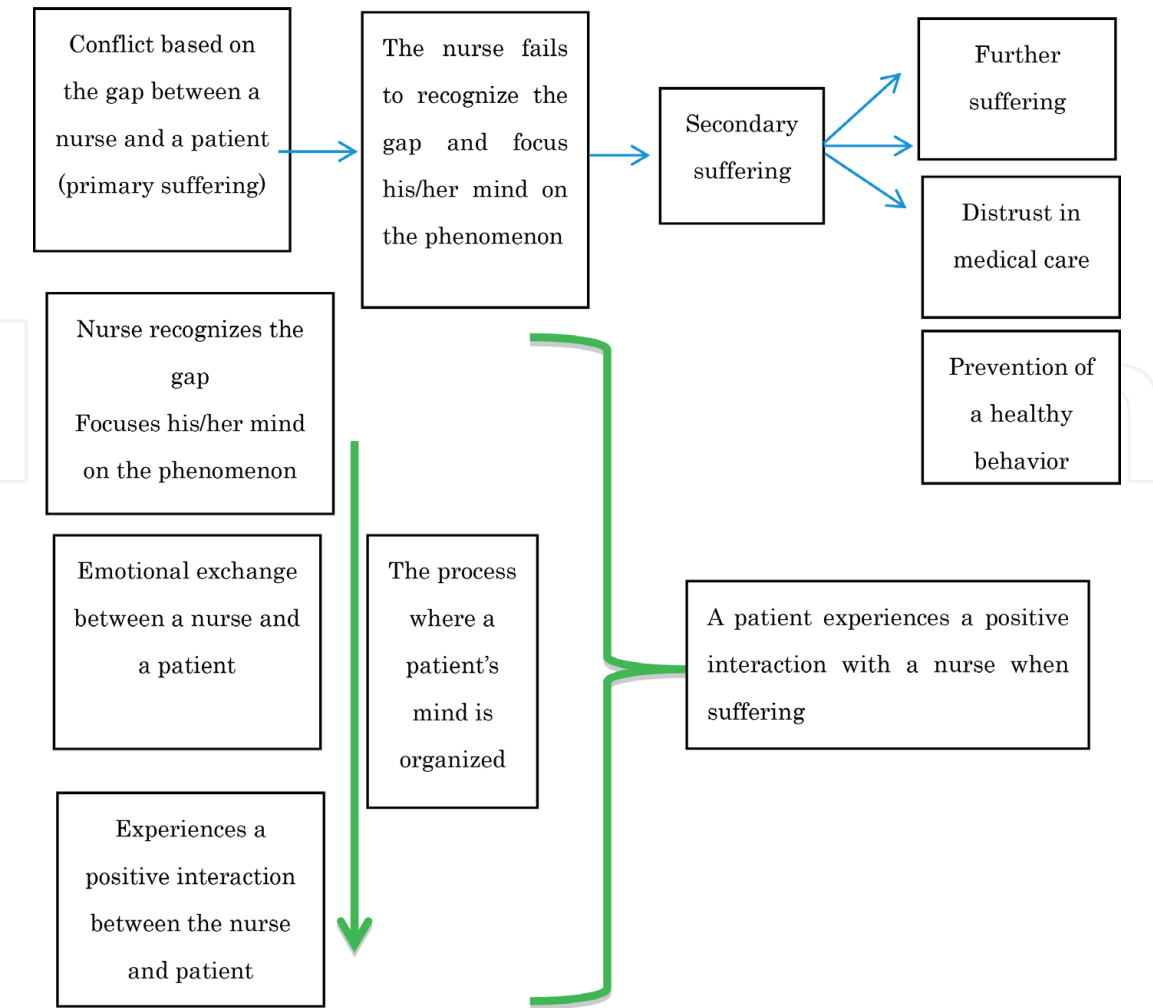
When a conflict arose, systematic thinking, including logical thinking based on EBP and empathic understanding of patients based on PCC, was observed in nurses. Meanwhile, patients carried fragmented emotions, such as “anxiety,” “sorrow,” “dejection,” and “anger.” In other words, when I simultaneously looked at the perception of nurses and patients, there was a gap in perception, which was observed as “nurses’ systematic understanding” and “patients’ fragmented emotions.”

### 10.2 Positive interaction as a result of nurses recognizing the gap in perception

After looking at the perception of nurses and patients simultaneously, we found that there was a gap observed as “nurses’ systematic understanding” and “patients’ fragmented emotions.” When a nurse recognizes this gap in perception, a nurse senses the fragmented emotions that a patient carries while engaging in systematic thinking and understanding. Alternatively, the gap was naturally filled by the nurse placing himself/herself in the patient’s shoes to understand the latter’s emotions, then a positive interaction would be observed when the nurse expressed empathic understanding toward the patient and shared his/her suffering.

### 10.3 Suffering based on the gap in perception between nurses and patients and a positive interaction model

In Study 1, we showed that the empathic attitude of a nurse, who recognized the gap between the nurse and patient, resonated with the patient at a soul level. This resulted in a positive interaction where the gap in perception between the nurse and patient was recognized, enabling emotional exchange. Building on these findings,



**Figure 1.**  
*Suffering based on the gap in perception between a nurse and a patient, and a positive interaction model.*

I constructed a model for suffering based on the gap in perception between nurses and patients, and positive interaction (**Figure 1**).

#### 10.4 Structure and definition of the constructed conceptual model

The perception and cognition of phenomena that occur in nursing settings differ between nurses and patients. Nurses encounter various situations related to patients' life and death and experience emotional fluctuations associated with them on a daily basis. Meanwhile, life change caused by hospitalization, although it may be for a short period, is a once, if not only a few times, in a lifetime experience for the patients. As such, because nurses and patients are in different positions, they have different ways of understanding a phenomenon and standards of perception. I elucidated this difference as a gap. Based on what has been described, suffering experienced by a patient was defined as primary suffering. With regard to primary suffering, if the nurse does not recognize conflict and the gap that causes it, the patient will notice the nurse's lack of awareness of it. In other words, the patient experiences secondary suffering when he/she instinctively and intuitively senses the nurse is not truly willing to help the patient who is experiencing primary suffering. As a result, the patient suffers even more, giving rise to distrust in medical care, interfering with his/her health behavior.

If the nurse adequately understands the gap that caused the conflict and comes to feel the emotions of the patient unintentionally and in a natural way, emotional exchange takes place; this cultivates a positive interaction. This process is considered the "process by which the patient's mind is adjusted."

## **11. Discussion: examination of nurses' and patients' perception of the cause of nurse-patient conflict**

### **11.1 Cause of nurse-patient conflict**

Nurses interact with patients at a more intimate level than other health care workers and are committed to life-threatening moments and important life events. As such, nurses have more opportunities to obtain information about patients. Excess and insufficient information can cause conflict. Nurses also witness patients undergoing a great deal of emotional fluctuations. However, they are anxious because they feel that they may no longer be able to engage in "nursing work" if they accept patients' emotions as they are. Washida [108] described such situation as the critical point in clinical practice and where the patients suffer. In several ways, nurses are unable to put it together unless they become objective and distance themselves from emotional fluctuations. It may be that they are able to continue "nursing work" by unconsciously numbing their emotions. The data have shown that conflict is attributable to the gap between nurses and patients.

### **11.2 Potential opposition of conflict and suffering**

The data of the present study was obtained by applying Robbins's [100] framework for conflict process. Nurse-patient communication and trust are believed to be involved in potential opposition. As Usui [109] stated, laypeople remain in a limited understanding of superficial phenomena, whereas experts can penetrate the internal structure of the subject with the help of expert knowledge. Nursing professionals are able to and are expected to enter into a patient's inner state and respond accordingly. However, when nurses are unable to meet these expectations, secondary suffering arises, and patients experience even more anguish.

### **11.3 Gap in perception between nurses and patients caused by conflict**

#### **1. Perception of nurses and patients caused by conflict.**

There was a gap in perception between nurses and patients with regard to conflict. It was observed that nurses tended to understand phenomena using logical thinking, based on EBP, and empathic understanding, based on PCC. This is because nurses were trained as professionals and accustomed to understanding perceived phenomena using scientific thinking and grasping a patient's feelings based on clinical experience. By contrast, patients, who had not received specialized education and whose physical condition had deteriorated, perceived and responded to phenomena with fragmented emotions. Therefore, there was a gap in the perception between nurses and patients. There appears to be a gap between the experience of nurses and patients as humans systematize their experiences and attempt to give them meaning ([89], p. 88).

#### **2. Four aspects of nurse-patient perception gap.**

There was a difference in perception between nurses and patients in situations where a conflict had arisen. There was a gap in communication between them in terms of communication for conveying their perception. In a nurse-patient relationship, communication is not only limited to the process of simply sending/receiving verbal or non-verbal messages but also includes a wider range of information [110]. A gap is created when one fails to receive the information sent. In addition, it has been suggested that communication aimed at ensuring quality of



nursing helps develop a positive nurse-patient relationship [111–113]. Attention should also be paid to the relation between the two.

### 3. Nurses' recognition of the perception gap.

There was a gap in perception between nurses and patients in situations where a conflict had arisen. Whether nurses recognize this gap affects the way they influence patients. Nurses will not give any thought to patients' emotions unless they are aware of the gap. Recognizing the gap between nurses and patients is the first step in achieving true empathy.

## 11.4 Emotional exchange between nurses and patients

### 11.4.1 Emotional exchange

In the present study, we also focused on the fact that patients come to experience an emotion because of conflict. Emotional exchange was defined as sending "emotional" messages to whom one feels safe to express "emotions" and share his/her emotional world as a result of them receiving those "emotional" messages as they are.

Nurses were able to notice and share patients' anguish owing to the empathic interaction in which they recognized the gap with patients. Emotional intelligence (EI), which is the ability to sense patients' emotions, on the nurses' part is believed to be involved in the process. EI is the ability to understand emotion accurately, utilize emotion to facilitate recognition, and reflect on emotion [114], in addition to one's own motivation and human relationship skills (Goleman 1995). EI was internationally acknowledged as a result of Goleman's (1998) "Working with Emotional Intelligence." Nurses, whose profession involves interaction with others, are required to have a high level of EI, particularly the ability to sense patients' emotions and respond accordingly.

### 11.4.2 Empathy and suffering

The word empathy was derived from the Greek word "empathia," which was formed by combining em (to attempt to insert) and pathia (suffering). The Oxford English Dictionary defines empathy as "the ability to project personality on the subject of reflection (and to perfectly understand it)." It is a term primarily related to the field of psychology.

We believe that feeling a patient's feelings/intentions and standing by them are equal to showing an interest in his/her concerns. Nurses are equipped with not only the ability to logically understand matters but also the sensitivity to acknowledge the emotions patients experience as a person. Intentional empathy is often considered as the act of entering into others' emotions [115]. To stand by the patients, it is key to interact with them while acknowledging the gap and for nurses to place themselves in the thoughts of patients.

### 11.4.3 Sharing of suffering

Patients are in a state of distress, and they find the act of conveying the fact painful (suffering). Moreover, they suffer from the pain of not being empathized and understood. In short, their suffering is two-fold. Emotions of "anxiety," "sorrow," "dejection," and "anger" experienced by patients constitute primary suffering;

secondary suffering arises when they are unable to engage in emotional exchange with nurses [99]. Even if patients' suffering is not resolved altogether when a conflict arises, showing concern for their suffering and approaching their wishes by coming from the same state are considered sharing of suffering. Nurses must show concern to patients' emotions, which Nightingale [116] called the question about "the understanding of the things one is in the process of doing"; it is "the ability to put oneself in another person's shoes, the ability to understand intuitively what that person needs, and the ability to take on the fate of that person." These are unique to nursing.

## **12. Examination of the suffering based on the perception of nurses and patients, and the significance and validity of a good interaction model**

In the present study, we focused on the mentally/physically non-critical situations of patients in which issues, such as patients' depressive feelings that do not pose a medical or nursing problem, were not recognized as requiring nursing intervention and thus overlooked. The purpose of the study was to elucidate this concept.

Data showed that both experienced and newly recruited nurses with an active imagination had an intuition that "something was different about the patients," or "something had happened," or "something was wrong." An "awakening" takes place when one intuitively grasps a patient and distances oneself from this understanding. How, then, is this possible? This is achieved by providing nursing care while caring for a patient and wishing to understand the inner state of that person, that is, "passion" exuding from a nurse's personality that is beyond the technical limits of communication skills and empathic understanding. It may be technically possible for a nurse to perceive a gap and attempt to focus his/her mind on phenomena. However, to go a step further, techniques alone are not enough. Patients must be able to feel that they are fortunate to have met the nurse and are emotionally relieved. We were able to demonstrate that striving to be such a nurse results in high-quality nursing practice and shows the profundity of a practice involving humans.

"Passion" exuding from nurses is said to fall under the scope of nurses' individual ability. This area has been regarded as part of personal capability and appeal. It has not been academically studied because of the lack of clear training methods or evaluation indices for exploring it. However, without considering the relationship with patients and giving thought to this area, true improvement of quality as perceivable by patients is not possible. I was able to suggest the need for academic inquiry by the model of the present study.

## **13. Validity examination of the conceptual model by clinicians and its contribution to clinical practice**

We explained the purpose/results of the present study and the final model to clinicians to ask for their opinions and examine the validity of the model. We asked for the opinions of three individuals with 30–40 years of nursing experience, who understood the intent of the present study, and who previously worked in acute wards and currently belong to the field of visiting nursing care.

First, it should come as no surprise that the relationship with patients does not deepen by examining the horizontal line (the flow from primary to secondary

suffering) of the model. In fact, we visited patients who experienced secondary suffering as visiting nurses. Therefore, it was approved that nurses' involvement with primary suffering was important based on the opinion that "a patient may not have been so stubborn if the nurses had engaged at a slightly deeper level during the hospitalization period." Next, based on the examination of the vertical line (the flow from primary suffering to positive interaction), it was agreed upon that in some cases, a positive encounter with a nurse may be more important than curing the disease itself. In recent years, being able to engage in emotional exchange with nurses provides a positive interaction experience for those who are more than likely to have no one close-by to understand them, as an extremely large number of patients are living with chronic diseases and family morphology changes as they age. Consequently, clinicians endorsed the validity of the model. It was shown that there is a need to recognize this study's model in and its possible contribution to clinical practice. Therefore, I believe that the model created in this study represents everyday scenes for nurses and patients and is useful for reaffirming the fact that it was overlooked and not recognized.

## **14. Conclusion**

Nurse-patient relationship as a result of nurse-patient conflict depends on the way one looks at "communication" and "trust." Its interaction may involve drawing strength from patients as the power of nursing. It was shown that sharing of suffering by emotional exchange was a key concept for it. Washida [108] stated that the relationship between those being admitted and those accepting them is reversed in hospitals. Washida added that clinical settings are the critical plane on which those receiving care and those providing care come in contact in an inverted manner. The nurses working there become partly exhausted because of work responsibilities and the physical demands of work, but more so because they experience extreme emotional fluctuations multiple times a day. These emotional fluctuations rarely happen to average people. Amid these fluctuations, nurses are believed to maintain their balance by unconsciously getting out of touch with patients' myriad emotions and feelings while using scientific thinking at all times to avoid being affected by these fluctuations. With regard to the difficulty in listening, Kawai et al. (2003, p. 211) stated that "narrative does not trickle down in front of those who look for narrative, while it reveals itself only a little to those who patiently wait for it." Kawai and colleagues explained: "unless one is convinced that others will accept whatever he/she says and that they will follow through with the various problems that may arise as a result of him/her speaking out, he/she will not speak about the entangled thoughts he/she has. To speak means one becomes multiplexed in front of others and will unstably float around with no visible landing point." Patients suffering from a disease have a heightened sensitivity. They are probably able to intuitively sense whether nurses that are taking care of them are mature on the inside. What is important to patients is that nurses make an earnest effort to engage with them. They are pleased with this effort, and they perhaps do not expect nurses to completely understand them, the patients who are in great distress.

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