The Lived Experience of Graduate Entry Nursing Students' Development of Empathy in Clinical Practice: A Hermeneutic Phenomenological Study.

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Abstract

In this study, I aimed to understand the lived experiences of Graduate Entry Nursing (GEN) students and their development of empathy in clinical practice in Aotearoa New Zealand. Empathy is a fundamental nursing quality that fosters trust, connection, and therapeutic relationships between the health professional, health consumers and their whānau (family). Empathy is a nursing quality that can be both taught and learnt, yet the experience of developing empathy for GEN students had not been researched. As such, this study sought to understand the lived experiences of GEN students in Aotearoa New Zealand and how they experience the development of empathy, a fundamental quality of nursing practice, in clinical practice.

The research methodology, hermeneutic phenomenology, influenced by the works of Heidegger, Gadamer, van Manen and Benner, was selected due to its appropriateness for this study. Hermeneutic phenomenology seeks to understand the lived experience of a phenomenon, which in this case was the development of empathy. Seven GEN students volunteered to participate in this study. One-to-one interviews were conducted, recorded, and transcribed for meaning-making using van Manen's six-step process.

The findings from this study revealed three main themes from the students' experiences. These findings offer valuable insights for nurse educators, preceptors, tertiary institutes, and the nursing profession. This study contributes to a broader understanding of nursing students' experience of empathy development in clinical practice. It provides insights crucial for tailoring support to GEN students and future cohorts.

This thesis is a testament to the transformative power of pausing, listening, understanding, and taking the time to connect with others through shared humanity.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Microsoft Copilot

In accordance with the 2025 Auckland University of Technology (AUT) Postgraduate Handbook, I confirm that I have appropriately used artificial intelligence (AI) tools during the preparation of this thesis. Specifically, Grammarly was used to assist with grammar and spelling corrections, Microsoft Teams was used to transcribe interviews conducted on the online platform, and Copilot was used in a limited capacity on a pre-written version of the thesis to help ensure thematic consistency and coherence across sections. The use of AI was restricted to supporting tasks and did not replace my own critical thinking, research, analysis, or academic writing.

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10th December 2025

Acknowledgements

> Ehara taku toa i te toa takitahi, engari he toa takitini. My success is not mine alone, it is the success of the collective (Elder, 2020, p. 145).

The path travelled while fulfilling the Master of Philosophy degree is one that I could not have travelled alone. I would like to express my gratitude to all those who have supported and encouraged me along the way. This thesis is not my success alone; it is the success of many.

First, I want to extend my appreciation to the student participants who graciously shared their time and stories from clinical practice with me. This study would not have been possible without their generosity.

To my supervisors, Dr Kay Shannon, Dr Heleen Reid, and my previous supervisor, Associate Professor Rachel Macdiarmid, thank you for your support, guidance, and the continual reminder of the importance of this work. I am grateful for the hours of mentoring and guidance I have received over the past two years.

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Each of you has played an integral role in shaping this thesis and my personal and professional growth. Ngā mihi nui (thank you).

Dedication

I dedicate this thesis to my grandmother, Fay.

Your gift was teaching me that people and education are the two most important aspects of life. You encouraged me to learn and to care, and to see education as something that continues throughout life. A process of growing and blooming, just like the flowers in your garden.

Ethics Approval

This study sought ethics approval from the Auckland University of Technology Ethics Committee (AUTEC) in November 2023. The study was approved in December 2023. Ethics approval number: 23/364. Please refer to Appendix A.

Amendments to the recruitment process were necessary along the way due to difficulties in recruiting student volunteers. These amendments were requested by AUTEC and approved prior to the implementation of these changes. Please refer to Appendix H and Appendix I.

Statement of Terminology

Use of the term 'Patient'

The word 'patient' is a term used throughout this study to describe a person seeking health care. The rationale for using the word 'patient' instead of 'people,' 'person seeking healthcare' or 'person receiving health services' is due to the commonality of its use and place in nursing and medical practices. However, the use of the term 'patient' can dehumanise individuals who would prefer not to be labelled as being a 'patient' (Costa et al, 2019). Moreover, dehumanising others does not align with the chosen philosophy for this study, hermeneutic phenomenology (Hoogendoorn et al., 2023). However, despite recognising this, I have maintained the use of the word 'patient' throughout the thesis. Costa et al. (2023) conducted a study that demonstrated health professionals prefer to use the term 'patient' when compared to the alternative, 'consumer'. Therefore, throughout this thesis, to distinguish between people, GEN student participants, RN preceptors, and CEs, I have decided to use the word 'patient' to describe a person seeking health care. The exception to this is when a GEN student has used an alternative word, such as 'client' or 'whaiora' (person seeking health) (Moorfield, n.d.-d) to describe a person they were caring for. To expand on this, the term 'patient' can be used interchangeably with te reo Māori word, 'whaiora' (person seeking health) (Moorfield, n.d.-d) in Aotearoa New Zealand. Some GEN student participants spoke of their experiences with Māori and chose to use the te reo Māori word whaiora (person seeking health). Others used the term 'client' when speaking about an experience in a mental health care setting. In these circumstances, I have maintained the participant's chosen word used to describe the person they were caring for, as this was the participant's choice of wording, and I wanted to respect this decision.

It should be noted that a study by Hoogendoorn et al. (2023) suggests that dehumanising behaviours in healthcare are unconscious and unintentional but can negatively affect the emotional wellbeing of others. Concerning empathy, this study suggests healthcare professionals can unconsciously, through an emotional regulation strategy, dehumanise others by avoiding seeing the suffering of others to prevent feeling emotionally exhausted and overwhelmed (Hoogendoorn et al., 2023). While I do not seek to understand the dehumanising behaviours that can present when empathy

is lacking, it did, however, seek to understand the experiences of developing empathy, which makes this article relevant and important to mention.

Use of Hyphens

Hyphens are commonly used in hermeneutic phenomenology (Gadamer, 1975). Hyphens demonstrate an integrated and fluid relationship between ideas and concepts in this methodology. van Manen (2014) notes that hermeneutic phenomenology is not a fusion of two methods but a mode of inquiry that embraces both the interpretive nature of human understanding and the richness of lived experience. I had used hyphenated terms, such as "being-with," "lived-time," and "being-with-others," throughout the thesis, particularly in the findings and discussion chapters (Chapters Five and Six), to reflect key concepts in phenomenological language. The use of hyphens in these expressions is intentional. It follows the tradition of phenomenological scholars such as Heidegger and van Manen, who utilised hyphenation to signal the interrelatedness and fluidity of lived experience (van Manen, 2014; Heidegger, 1962). These hyphenated terms emphasise that such experiences are not discrete or static but inherently relational and temporal. The hyphen functions symbolically as a conceptual bridge, compounding words together and placing emphasis on the dynamic interconnectedness between meaning-making and experiential insight.

Positionality Statement

I entered this research as a Registered Nurse (RN) and Clinical Educator (CE) with over ten years of clinical practice experience. My understanding of empathy has been shaped by bedside care, relationships with patients and families, and the realities of contemporary health care. In keeping with hermeneutic phenomenology, I do not claim neutrality. My interpretations are informed by my professional experiences, values, and commitments. Through my practice, I have witnessed both meaningful expressions of empathy and the ways systemic pressures can constrain it. These experiences have fostered a strong commitment to supporting more intentional and sustained empathetic practice within health care and nursing education. As an educator working within the current nursing curriculum, I am attentive to how empathy is understood and cultivated in future nurses. By acknowledging my position within this work, I aim to remain reflexive and transparent, recognising that meaning emerges through the interaction between participant narratives and my own professional context

List of Abbreviations

AUTEC	Auckland University of Technology Ethics Committee
CE	Clinical Educator
CNM	Clinical Nurse Manager
GEN	Graduate Entry Nursing
GP	General Practitioner
NCNZ	Nursing Council of New Zealand
NZNO	New Zealand Nurses Organisation
NUM	Nurse Unit Manager
RN	Registered Nurse
RM	Registered Midwife
WHO	World Health Organisation

List of Commonly Used te reo Māori

Table 1. Glossary of commonly used te reo Māori

Words in te reo Māori	**Closest translation in English**
Aotearoa	New Zealand, “land of the long white cloud”
hui	gathering, meeting, assembly, seminar, conference
kanohi ki te kanohi	face to face; the social meaning of the phrase emphasises physical presence and even a sense of commitment to whānau (family), to a place, to a kaupapa (purpose).
kawa whakaruruhau	cultural safety within the context of nursing Māori
kōrero	speech, sharing of stories
manaakitanga	show respect, kindness, hospitality, support
Māori	indigenous peoples of Aotearoa New Zealand
mihi	speech of greeting, acknowledgement, tribute
noa	safe and unrestricted, denotes an absence of limitations or conditions
Pākehā	non-Māori European
tāngata whenua	indigenous peoples of the land
tapu	sacred or prohibited, restricted
te Ao Māori	Māori world view
te reo Māori	the Māori language
te Tiriti o Waitangi	the Treaty of Waitangi
whakawhanaungatanga	process of establishing relationships
whānau	extended family, family group
whanaungatanga	relationship, sense of family connection

(Hunter & Cook, 2020. p. 23).

List of Definitions

Clinical Educator: A Registered Nurse (RN) who works with students directly in clinical practice settings with a primary role of educating students, but also offers space to debrief, support, guide, and teach students specific skills that are transferable across all areas of nursing practice and in specialised areas of nursing practice.

Clinical Practice: A clinical environment where RNs work with members of the public to promote health, wellbeing, and help to relieve the burden of conditions. These settings can be private or publicly funded areas, including, but not limited to, mental health services, community nursing, General Practitioner (GP) clinics, hospital wards and units, and residential care facilities.

Empathy: A fundamental nursing attribute, as empathy fosters connection, shared understanding between health professionals, patients and their whānau, and it is evident from literature that it helps to improve patient health outcomes as it improves emotional health. For the purpose of this study, empathy is defined as: A cognitive attribute that involves understanding the feelings of another's experience and seeing the world as others see it, through non-judgmental eyes, and the ability to communicate this understanding back to the other in a space that they find emotionally safe (Hojat et al., 2018; Levett-Jones et al., 2019; López-Martínez et al., 2023; Wiseman, 1996). The choice for this definition is explained in Chapter One and in Chapter Two and challenged in later chapters as my interpretation of empathy evolved.

Graduate Entry Nursing (GEN) Student: A graduate of an undergraduate degree (typically health-related) who is seeking a master's degree and wishes to pursue a career in nursing. This master's degree is an accelerated two-year pathway to fulfil the requirements needed for students to sit the Nursing State Exam set out by the Nursing Council of New Zealand (NCNZ).

Hard skills: The knowledge, actions, and technical skill performance of an RN in clinical practice (Song et al., 2024).

Nurse Preceptor: An RN assigned to work with student nurses. The role of the preceptor is to work alongside the student nurses to promote safe and competent clinical practice of the students. They guide students to use and follow clinical setting policies, procedures and guidelines that belong to organisations.

Registered Nurse (RN): A Registered Nurse (RN) in Aotearoa New Zealand is a qualified healthcare professional who delivers safe, evidence-based, and culturally responsive care. Grounded in Te Tiriti o Waitangi (the Treaty of Waitangi), RNs uphold cultural safety and promote equity, especially for Māori as tāngata whenua. RNs work independently and collaboratively to assess, plan, and evaluate patient care (NCNZ, 2025). RNs are accountable for their practice, may prescribe medications within scope, and often contribute to leadership, education, or research. They also guide and delegate to other healthcare team members (NCNZ, 2025).

Registered Midwife (RM): An individual who has completed the required bachelor's degree and who has satisfactorily fulfilled the requirements set out by the overarching registrational board for their country. In Aotearoa New Zealand, this is the Midwifery Council of New Zealand (Midwifery Council of New Zealand [MCNZ], n.d.). Thereafter, the individual is deemed qualified and confident to care for women and children during pregnancy and up to six weeks postpartum in community and hospital settings.

Soft skills: The self-reflection, beliefs, values, communication and attitudes of RNs when working with members of the public and with other health professionals (Song et al., 2024).

Undergraduate Degree: Also referred to as a bachelor's degree, an undergraduate degree is the first degree obtained at tertiary level, typically obtained at a university or another tertiary institute.

Chapter 1 Introduction

> "It has become more widespread that the success of medical science by itself will never provide us with answers to all the problems of medical science" (Svenaeus, 2000, p. 63).

1.1 Introduction

This first chapter serves as a foundation for this qualitative hermeneutic phenomenological study, which explores the lived experience of Graduate Entry Nursing (GEN) students' development of empathy in clinical practice in Aotearoa New Zealand. Empathy, as explained by Levett-Jones et al. (2019), is a complex communication skill and a nursing attribute that requires time, understanding, and practice to achieve the desired outcome. The desired outcome of acting empathically is to understand the feelings, emotions, and moods of others (Levett-Jones et al., 2019). Empathy is referred to as a fundamental nursing attribute as empathy fosters connection and shared understanding between health professionals, patients and their whānau (family) (Hojat et al., 2018; Levett-Jones et al., 2019; López-Martínez et al., 2023; Wiseman, 1996). Moreover, literature suggests that empathy contributes to improved patient health outcomes, as it can improve the emotional well-being of another (Hojat et al., 2018; Levett-Jones et al., 2019; López-Martínez et al., 2023; Wiseman, 1996). Empathy is an attribute that should be used to build relational care between health professionals and patients, as it has been proven to optimise health outcomes (Eklund et al., 2019; Sanderson & Brewer, 2017). Therefore, empathy is also considered a nursing graduate attribute, as it is crucial to fostering therapeutic and professional relationships (Eklund et al., 2019; Sanderson & Brewer, 2017). Central to this study is the recognition that empathy is more than just a communication tool.

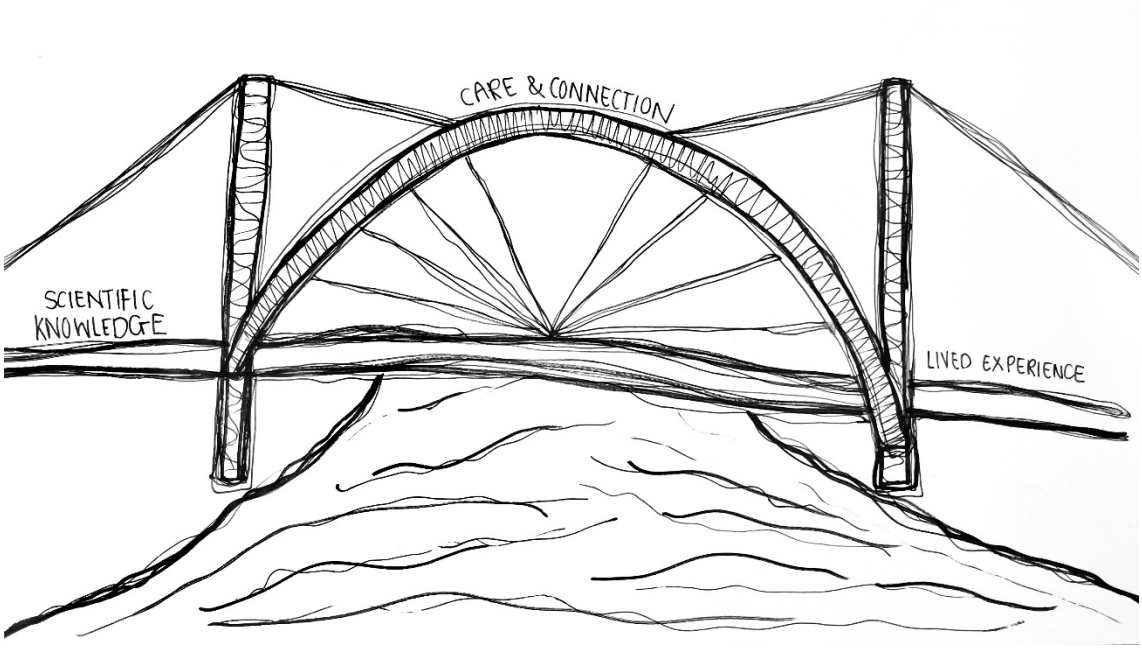
Riess (2022) suggests empathy is a concept that can be learnt and taught. However, it is not clear from the literature what the experience of developing empathy is for GEN students during their clinical practice experiences. This chapter will provide brief background information on empathy, GEN students, GEN programmes in Aotearoa New Zealand, clinical practice settings, and outline some of the key terms used throughout this thesis. I share the significance of this research and my journey to this research topic, which offers insights into the motivations and relevance of this study to

my work as an RN and CE. I also share my pre-reflective interview, discuss the aims of the research and conclude by providing an overview of the subsequent chapters.

This chapter begins with an opening quote that was selected for how it resonates with me and my key motivation behind conducting this research. As a health professional, I have a passion for working *with* people and listening attentively to their stories. Connecting with people from all walks of life drives my commitment to exploring areas within healthcare settings where medical science alone falls short. This is particularly true for the lived experiences of others. By engaging empathetically with the stories of others, in this study, I aimed to bridge the gap between scientific knowledge and human experience, thereby enhancing care and connection.

Figure 1

Illustration: Bridging research



I wanted to illustrate this metaphorical bridge between scientific knowledge and human lived experience (Figure 1). I have drawn two pillars of the bridge, representing scientific knowledge on one side and lived experience on the other. Both are essential foundations in nursing and healthcare, yet they often stand apart in practice and education. Between them stretches the arch of care and connection. By situating my research within lived experience, I aim to highlight what is often missing when nursing education prioritises technical proficiency or scientific expertise alone. In the bridge

metaphor, I aim to capture a movement across care and connection that brings together scientific knowledge and human lived experience.

1.2 Brief Background

Nursing education in Aotearoa New Zealand, witnessed a significant shift in the last decade. In 2014, the GEN programme was introduced (Jamieson et al., 2020). GEN programmes are accelerated, intense two-year pathways for graduates of non-nursing degrees (Shannon et al., 2024). Unlike the Master of Nursing programme, which is designed for already-registered nurses (RNs) to advance their nursing education, the GEN programme offers non-nursing graduates the opportunity to become Registered Nurses (RNs) through postgraduate study, additionally gaining a master's qualification (Shannon et al., 2024; University of Auckland, n.d.-a). The alternative pathway to become an RN is the traditional three-year undergraduate degree in nursing (Ministry of Health, 2024; Nursing Council of New Zealand [NCNZ], 2024).

The nursing profession in Aotearoa New Zealand is regulated under the Health Practitioners Competence Assurance (HPCA) Act 2003 (n.d.), with oversight provided by the Nursing Council of New Zealand (NCNZ, n.d.-b). The Nursing Council of New Zealand sets and maintains standards for nursing education and practice, including the final examination to ensure that all graduating students are competent and safe to enter professional practice (NCNZ, n.d.-b). GEN programmes and undergraduate pathways to nursing registration require students to meet the standards set by the Nursing Council of New Zealand (NCNZ, 2024). These requirements include passing all academic components of nursing programmes, completing a minimum of 1000 hours of clinical practice, and successfully passing the Nursing State Examination, set out by the Nursing Council of New Zealand (NCNZ, 2023; NCNZ, n.d.-a).

Clinical placements form a critical component of nursing education, offering both GEN and undergraduate students with diverse opportunities to develop the knowledge, skills, and attitudes required for registered practice. Clinical practice placements vary in settings throughout the nursing programmes, exposing students to a range of clinical contexts. Tertiary providers that offer nursing programmes have contractual obligations with clinical placement providers, which require them to ensure that students are adequately prepared to enter the clinical practice setting prior to their arrival in the

areas. This, too, reflects a broader expectation that student nurses are well-equipped with the knowledge and skills required to graduate as safe and confident RNs in clinical practice (Makarem et al., 2019). Despite preparation, some studies suggest that students are unprepared for this transition from student novice to beginner nurse by the end of their nursing education (Benner, 1984; Ortiz, 2016). In clinical placements, nursing students are supernumerary, which means they are not included in staffing numbers and must always be supported by a RN preceptor (Vellem & Jooste, 2025). While in clinical practice placements, students are expected to contribute to care, as they are still in a developmental phase, requiring guidance, supervision, and a balance of hands-on and observational learning opportunities (Vellem & Jooste, 2025).

Clinical placement environments are inherently dynamic (O'Mara et al., 2014) with staffing levels fluctuating hourly, roles of team members vary, patients' needs change consistently, and situations may rapidly shift from routine to critical (Liu et al., 2022). These unpredictable conditions challenge students to apply hard and soft nursing skills when under pressure (Liu et al., 2022). Hard skills include hands-on clinical procedures and technical knowledge, while soft skills involve bedside manner, rapport, therapeutic communication, and empathy (Betti et al., 2022). Hard skills can be simplified down into what nurses know and do (Song et al., 2022). Developing both hard and soft sets of skills in an ever-changing, dynamic environment can be demanding for nursing students, yet many rise to the challenge and demonstrate adaptability, resilience, and a growing sense of professional identity (Aryuwat et al., 2023).

1.3 My Journey to this Topic

I am a qualified RN and midwife (RM). Nursing and midwifery are unique liberal educations that display blends of art, medical science, social science, and humanities (Becker, 2003). They are also areas of health care known for being a blend of art and science (Oliveira et al., 2017; Becker, 2003). The 'art' of these professions can be described as the ability to care, be compassionate, show understanding, and communicate effectively with patients (Oliveira et al., 2017). The 'science' side is the understanding of pathophysiology, disease and illness processes, as well as techniques of care supported by research and applied during patient care (Oliveira et al., 2017). In

a way, this is a different way of viewing hard skills and soft skills in nursing (Betti, et al., 2022).

I value learning and education. Best practice care in nursing and midwifery is supported by research and evidence. Continuous learning and relearning are necessary in these professions as scientific evidence evolves daily (Vega & Hayes, 2019). These are professions that demand nurses and midwives to be in a repetitive cycle of learning, mastering, and relearning. As new research findings emerge regularly, learning and relearning become ongoing norms.

The art of social science, communication, understanding, and compassion, in my practice, is of enormous importance to me. The daily dance of learning and relearning sparked my curiosity to plunge into research. I enjoy the learning and reflective process experienced in healthcare and wanted to pursue a higher level of education for myself. Considering these two interests, the 'art' of working with people and the joy I find in learning, I applied for the Master of Philosophy degree, as it is an entirely research-based degree.

I came to this research with a clear intention to complete a research-based master's degree and certainty that I wanted to produce a robust piece of research that would not just benefit the nursing profession. I wanted to produce a body of work that comes from a place of curiosity and wonder. I wanted to create a piece of research that had the potential to directly change the way I and others work. However, I was uncertain about the topic, participants, setting, methods, and research methodology I would use to conduct this research. I chose to focus on nursing rather than midwifery due to its direct relevance to my current role as a RN and clinical educator (CE). By centring the research on nursing students, I hypothesised that I would be able to directly apply the findings to my current practice, to best support nursing students. This alignment between the research and my professional role made the study feel meaningful and impactful, with the potential to produce tangible outcomes that could influence my everyday interactions and teaching.

I have transitioned from working clinically in acute hospital settings to working as an RN/CE for a tertiary institute that offers both undergraduate and GEN programmes. The transition stemmed from a deep desire to make positive changes to

nursing practice and culture. I have observed that making these changes is difficult once a culture has already been established within a workplace. Therefore, I turned to wanting to work in an educational space where I could influence, inspire, and role-model the positive nursing practice that I sought while working as an RN in clinical areas.

I questioned the adequacy of the educational support provided to nursing students during their tertiary education, as student nurses are the future of the nursing profession. I feel that it is part of my responsibility to ensure students are receiving adequate support to be competent graduates. In my experience as a CE working with undergraduate nursing students, I have witnessed nursing students tending to place emphasis on the hard skills, the technical, hands-on qualities, with a task-focused, tick-box-oriented mindset. Because of this focus on hard qualities, I often see students struggle to develop effective therapeutic communication or empathetic care with patients, their whānau (family), colleagues or the multidisciplinary team. Hard and soft qualities are complementary; however, soft qualities are a prerequisite to effective and meaningful human interaction and teamwork (Laari et al., 2021). From this observation in clinical practice, and supported research from Laari et al. (2021), I knew I wanted to centre my research around soft skills.

Working with people and understanding their lived experiences is a sometimes-forgotten privilege of working within healthcare. I like to remind students of this when working with them. Reflecting on this, I immediately settled on undertaking qualitative rather than quantitative research. Communicating with people and hearing their lived experiences through spoken narratives is aligned with the joy of connecting with people. I liked the idea of focusing on the details and the quality of research as interpreted through descriptions and concepts rather than the meanings behind large quantities of numbers and statistical data.

Then, how did I come to researching empathy? Meeting with the research supervisors led to deep reflection and contemplation. The research supervisors suggested reading different types of qualitative research methodologies to inform the philosophical underpinnings of my research. During this process, I became intrigued by the concept of interviews as a means of data collection. Being interviewed is an act of courage, resilience, and vulnerability in itself, which I later found are integral qualities

needed to convey empathy (Tan & Caleon, 2022). These three concepts are ones I consistently encourage student nurses to uphold, value, and develop on a daily basis in their clinical practice. Moreover, I came to realise that participants also needed compassion, resilience, and vulnerability during the interview process. It was, therefore, fitting that I should research empathy. Empathy is a concept and quality that aligns with my interest in nursing education, and it was an area of student nurse development that I witnessed as an area for improvement for clinical practice. In addition, compassion burnout is a phenomenon that is on the rise within healthcare environments, which stems from passive coping in emotionally challenging and charged situations, rather than acting with empathy and resilience (Cao et al., 2021). I discuss more on compassion fatigue and its connection to empathy in Chapter Two.

I searched and read the available literature regarding nursing students and empathy development. To my surprise, a vast body of literature already existed. Initially, I felt stumped and deflated upon uncovering this. Since the concept of empathy seemed to have been extensively researched in nursing students over the past decade, I was unsure how to proceed. It was not until the next meeting with the research supervisors that I considered researching GEN students. There was a great deal of research on GEN students; however, the development of empathy in GEN students had not been researched in Aotearoa New Zealand.

1.4 Overview of the Study

Empathy is known to be a fundamental quality and attribute in nursing practice as it enhances health outcomes for patients (Vieten et al., 2024; Moudatsou et al., 2020). Despite this, the experience of developing empathy for GEN students in Aotearoa New Zealand has not previously been researched. As influenced by Martin Heidegger [1889-1976] and Hans-Georg Gadamer [1900-2002], hermeneutic phenomenology was selected as the research methodology due to its appropriateness for the research question. The philosophical frameworks of Max van Manen [1942 -] and Patricia Benner [1942 -] have been used to make meaning as I sought to interpret and understand the lived experience of GEN students.

GEN students who volunteered to participate in the study were interviewed and were asked to share their experiences related to empathy from clinical practice. My

responsibility during the interviews was to ask the participants questions and actively listen to their responses (Engward et al., 2022; Schmid et al., 2024). This method of collecting narratives and stories to make meaning from is well-suited to hermeneutic phenomenology and will be explored in more detail in the subsequent chapters. Narration and storytelling are methods of sharing information with others and can be employed in research to gain insight into the views and perceptions of others (Muindi et al., 2020). The narratives shared by the participants during interviews were then transcribed and interpreted to understand the main themes and ideas that emerged from these stories. Using words and language to express a lived experience is an exchange of information between the storyteller and the listener of the story (Riessman, 2002). Burgess et al. (2022) explain that storytelling helps to cultivate empathy in others, and in turn, empathy is essential if we are to understand the lived experiences that others generously tell. The findings section, 'Chapter five Findings: Being-Present, Being-With, Transformation', reflects my 'making-sense-of' or my interpretation of the narratives shared by the participants to cultivate a shared understanding of empathy development in clinical practice in Aotearoa New Zealand.

1.5 Study Aims

The aim of the study was to understand the lived experience of GEN students' development of empathy in clinical practice in Aotearoa New Zealand. Understanding the unique challenges and opportunities experienced by GEN students is crucial for providing them with the best possible support, guidance, and opportunities during their clinical placements, thereby developing competent graduate nurses. The cohort of GEN students was selected due to the limited research that exists for this group of nursing students, making this research unique and important for understanding the experience of GEN nursing students in clinical practice.

Moreover, the aim of this study was to produce a robust piece of research that would benefit the nursing profession. It was hoped that the findings of this study could inform educational strategies that promote empathy development among student nurses in tertiary institutions and nurses beyond tertiary-level education, working in educational and clinical settings.

The final aim of this research was to gain new and unexpected insights from the participants' narratives. I decided to capture the lived experience of empathy development from as many clinical practice settings as possible while acknowledging the limitations of conducting a qualitative master's research project. Aotearoa New Zealand has seven tertiary institutions that offer a GEN programme. Therefore, I decided to explore the lived experiences of GEN students from each of these institutes. The rationale for this decision stemmed from a desire to understand the development of empathy across the country. I hypothesised that the experience of empathy development may differ for GEN students depending on their geographical location. Ultimately, this led to the research question, which included the geographical location of the entire country of Aotearoa New Zealand. The research question evolved into: **How do GEN students in Aotearoa New Zealand, experience the development of empathy in clinical practice?**

1.6 Etymology and Definition of Empathy

Etymologically, the word empathy as we know it today in English derives from the Greek word *empatheia*, meaning ‘passion’ or a ‘state of emotion’ (Harper, 2024). The word *empatheia* comes from the combination *en:* meaning ‘in’ and *pathos:* meaning ‘feeling’ (Harper, 2024). In 1908, philosopher Rudolf Lotze (1817-1881) translated empatheia to the German word *Einfühlung* (ein meaning "in" and Fühlung meaning "feeling") (Harper, 2024). In English, the translation of empathy, taken from the Oxford Dictionary, is “the ability to understand another person’s feelings, experience…” (Oxford University Press, 2024). Today, ‘empathy’ is widely used among health professionals and is deeply embedded in literature; however, a definitive definition of empathy, specifically in literature related to nursing practice, remains blurred (Hojat et al., 2018; Wiseman, 1996).

Definitions of empathy in clinical practice and patient care found in academic literature lack unanimity despite the consensus on its importance in the clinical environment (Hojat et al., 2018). Due to the unanimity found in the literature, I reviewed a concept analysis of empathy to support my understanding. A concept analysis is used to clarify a term when the meaning and application of a concept become blurred. Wiseman (1996) completed a concept analysis of empathy and concluded that empathy

is comprised of four antecedents that must be present for the person to act empathetically. Without the antecedents, there is no empathy. The four antecedents of empathy, identified by Wiseman (1996), are:

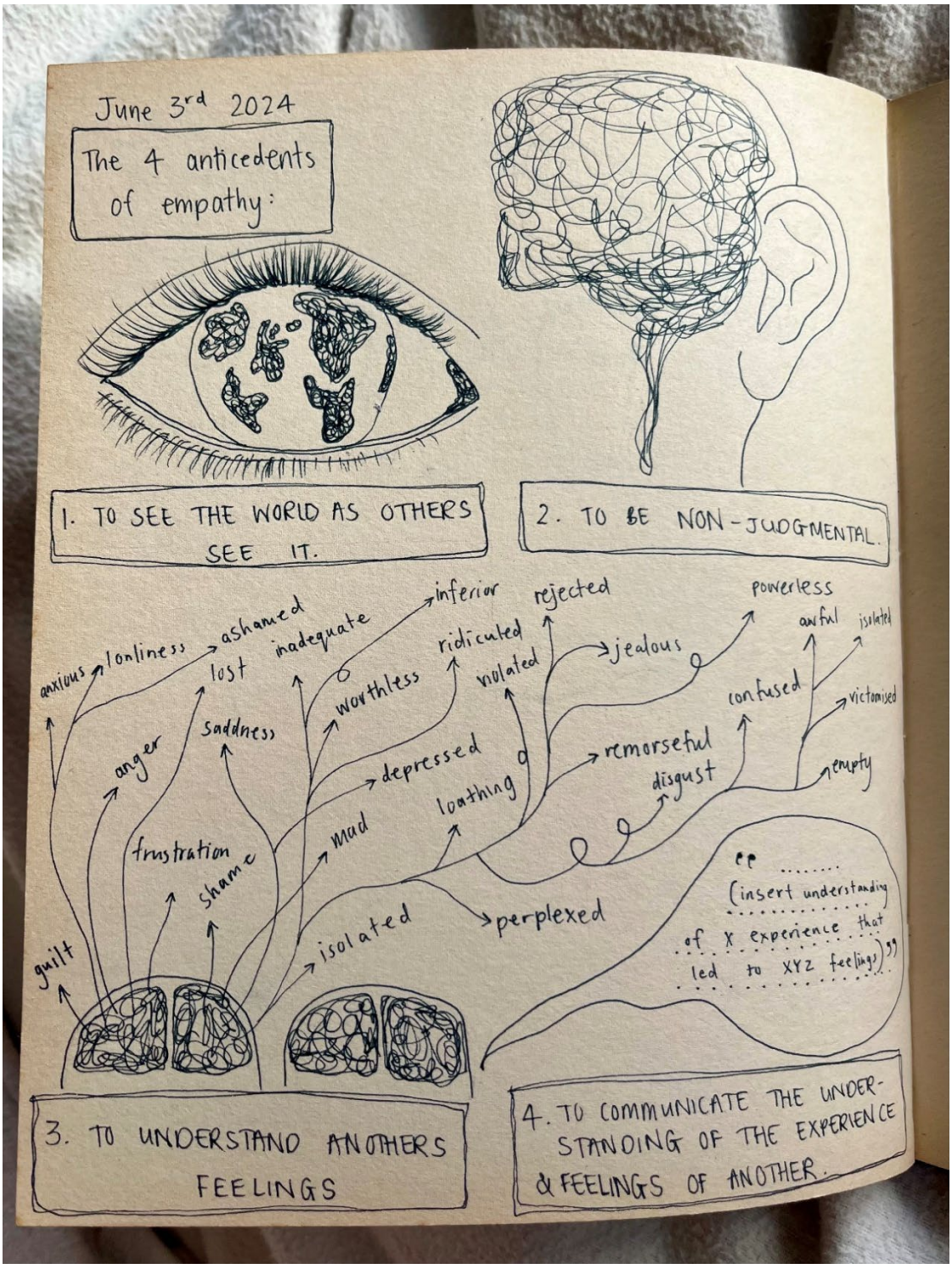
- To see the world as others see it,
- To be non-judgmental,
- To understand another's feelings,
- To communicate the understanding of the experience and the feelings of another.

Having now understood the antecedents of empathy, I endeavoured to find a definition of empathy that could be used in this study. This was challenging due to the inconsistent definitions in the literature. As human beings, "…we use language skills to explicitly convey information to each other, and social abilities such as empathy or perspective taking to infer another person's emotions and mental state." (Singer et al., 2024, p. 875). Levett-Jones et al. (2019) and López-Martínez et al. (2023) explain that empathetic care can only be provided in an emotionally safe and supported environment that is determined by the patient, not the provider of empathic care.

I could not find a definition of empathy that I agreed with from the extant literature due to slight variations. Instead, I used the working definition of others and the four antecedents to arrive at a working definition of empathy for this thesis. Therefore, empathy, for the purpose of this study, is understood as: A cognitive attribute that involves understanding the feelings of another's experience and seeing the world as others see it, through non-judgmental eyes, and the ability to communicate this understanding back to the other in a space that they find emotionally safe (Hojat et al., 2018; Levett-Jones et al., 2019; López-Martínez et al., 2023; Wiseman, 1996). However, my understanding and definition of empathy evolve in response to these changes. This is due to my own understanding of empathy deepening throughout the research process. So, while this is what I thought empathy could be defined as initially, this does change as my understanding changes.

Figure 2

Journal Entry: Understanding the four antecedents of empathy.



In developing this definition, I needed to visually see the antecedent. I wanted to illustrate how empathy is conceptualised in this study. Figure 2 captures how I interpret the antecedents of empathy and their interconnection. This image is taken from my reflective journal, where a lot of time was spent unpacking empathy and its complexities.

Figure 3

Journal entry: What empathy is not

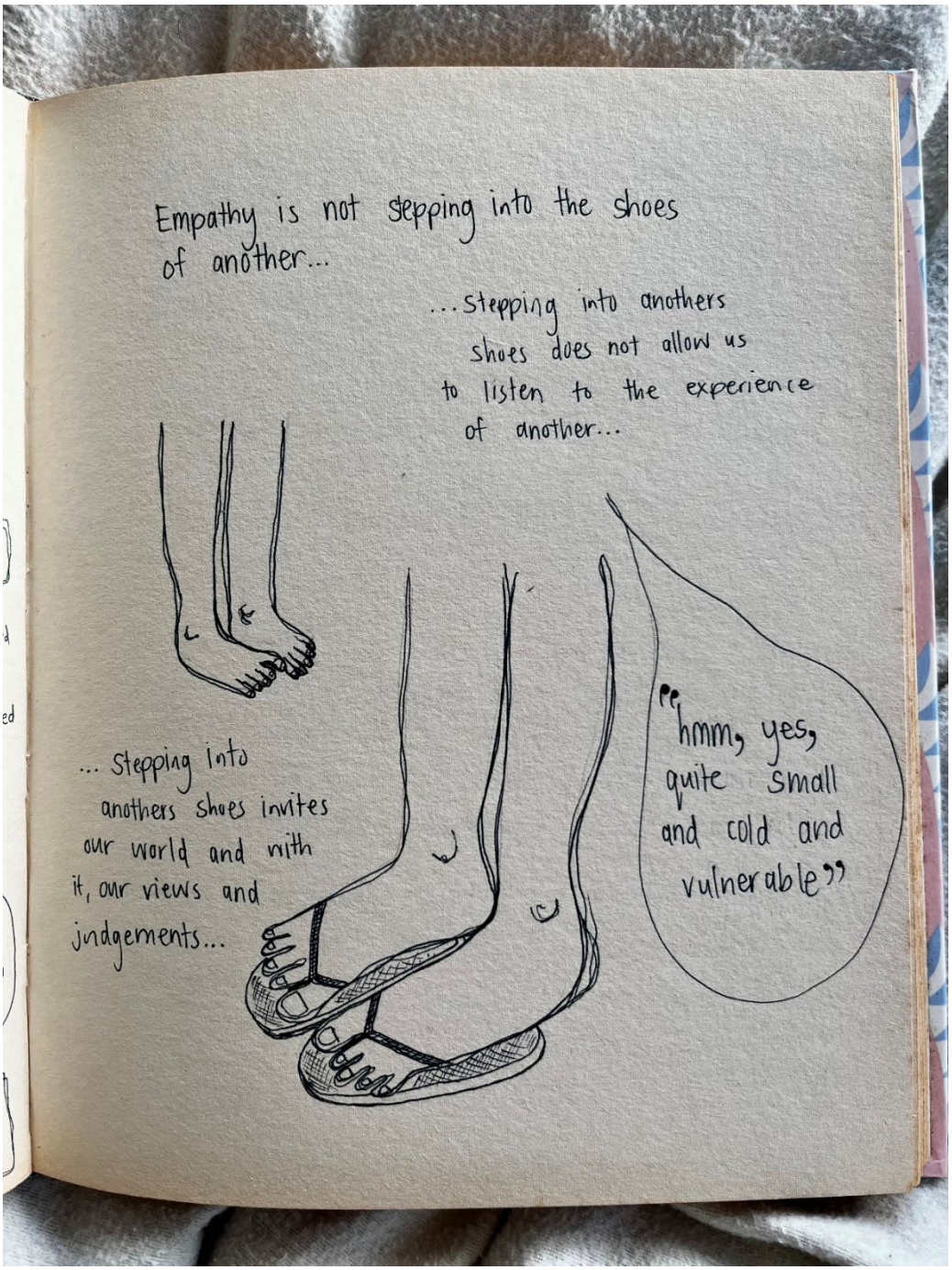


Figure 3 illustrates what empathy is not. While empathy can often be described as "stepping into another's shoes", this can take on or assume what the experience is for others, which risks overshadowing the unique perspective. Instead, empathy is about '*being-with'* the other, not *becoming* the other. This image is intended to clarify the distinction and reinforce the importance of maintaining boundaries while offering emotional presence and understanding in empathetic care.

1.7 Significance of this Study

This study is important because little is known about the experience of developing empathy in GEN students in Aotearoa New Zealand. The findings, outlined in Chapter Five, can contribute by enhancing the current nursing curricula and tertiary institutions' educational strategies used to support GEN students in developing empathy in their nursing education and in clinical practice. Understanding the lived experience of others, I believe, is a key we can use to unlock insight, interpretation, perception, and empathy for others. The first step to acting empathetically is to understand the experience of another and to understand their interpretation of a situation. It is therefore appropriate that I have used a hermeneutic phenomenological methodology to research the lived experience of GEN students and empathy development, as these concepts are woven and connected. GEN students have been researched in Aotearoa New Zealand, but not with regard to the experience of developing empathy. Understanding their lived experience of empathy development and support in clinical practice is needed to ensure that the necessary support and education are provided to the GEN student cohort.

1.8 Pre-Understandings

Literature suggests that researchers using hermeneutic phenomenology, guided by Gadamer's philosophy, should examine their pre-understandings (Alsaigh et al., 2021). I explain more on Gadamer's philosophy in Chapter Three – The Methodological Blueprint. Heidegger (1962) suggests that the 'self' and our way of being in the world is an accumulation of all we have experienced thus far in life. We cannot be where or who we are today, in the now, without our lived experiences from the past (Heidegger, 1962). This was particularly important for me to recognise as my background and lived experiences influence how I see, sense, and interpret information in my everyday life. To ensure rigour in my understanding, I conducted pre-understanding interviews with the research supervisors to reflect upon and understand my own perspective. This process helped to uncover prejudices that might have limited my openness to new insights, as unexamined biases may lead to assumptions that hinder deeper understanding (Alsaigh et al., 2021). As Dibley et al. (2020b) note, researchers must reflect on their past experiences, as they can influence their interpretation of

phenomena. This was especially important in hermeneutic phenomenology, where interpreting language and lived experiences is central to understanding meaning-making (Dibley et al., 2020b).

My pre-understanding of empathy was that it is not only an essential nursing quality but also a life skill. I believed empathy could be both taught and learned, but the extent to which someone develops empathy depends on their individual life experiences. Regarding GEN students, I assumed that this cohort of students would come to a nursing programme with more life experience compared to the undergraduate cohort of nursing students. This led me to believe that they would have a greater capacity for empathy as they would have more life experience to draw upon. This led to my pre-understanding that empathy development for GEN nursing during clinical practice would differ from that in an undergraduate nursing programme. I also understood that students entering programmes that include concepts from social science, such as nursing, often have greater inherent empathy as their work involves connecting with and understanding others. I believed that empathy could be taught to those lacking life experiences that enable them to relate to others' emotions, and that it is learned through life experiences that allow for deeper connections. I knew from my own experience of working with undergraduate nursing students that the development of empathy often resulted from what students saw and heard from those with whom they were working with. I noticed that professional role modelling, coaching, and self-reflection are beneficial attributes for its development in clinical practice. This was particularly true for self-reflection when students compared their own thoughts, feelings, behaviours, and attitudes to those observed in others.

This process of self-reflection on key concepts is known in qualitative research as 'reflexivity' (Jamieson et al., 2023). Reflexivity involves examining one's beliefs, assumptions, and judgments and considering how they might influence the research process (Jamieson et al., 2023). This process can be confronting, forcing researchers to question how their personal views shape their work, which was something I certainly felt at times. Engaging with reflexivity at each step of the study enhanced the openness and transparency of the research (Jamieson et al., 2023). It was undertaken to maintain a pre-reflective stance throughout the research.

1.9 Overview of Chapters

The following section provides an overview of the chapters that weave this thesis together and a brief outline of what each chapter contains.

1.9.1 Chapter 1 Introduction

Chapter One has set the stage for what is to follow in this thesis. It has introduced the study by providing a brief background on empathy, GEN students, clinical practice, the research aims, and a concise outline of the study. Due to the complexities in the literature regarding the definition of empathy, this chapter also offered a definition of empathy for the purpose of this study. Moreover, the chapter also included my personal journey to research and my pre-understandings.

1.9.2 Chapter 2 Journey through Literature

Chapter Two is a review of extant literature on the phenomenon of empathy, nursing students, and clinical practice. This chapter explores a background of information on nursing students and empathy development within the context of clinical practice, which sets the scene for the rest of the study.

1.9.3 Chapter 3 The Methodological Blueprint

Chapter Three outlines the selected research methodology of hermeneutic phenomenology and the rationale for its use in this study. This chapter summarises how hermeneutic phenomenology informs and guides this study. This chapter explores the philosophical underpinnings of hermeneutic phenomenology, as well as the work of philosophers Heidegger and Gadamer, and how their contributions have offered a valuable way to make sense of and understand the human lived experience. Moreover, this chapter discusses the work of van Manen and Benner, and how their work in lived experience has helped guide, shape and inform this study.

1.9.4 Chapter 4 Research Methods

Chapter Four explains step-by-step the process or recipe used to conduct the research. This section of the thesis explains ethics approval, amendments, participant recruitment, storage of information, interviewing processes, and research considerations for Māori, as this research was conducted in Aotearoa New Zealand.

Moreover, the chapter explains what I did with the participants' narratives and how I interpreted them to make sense of the meaning that answered the research question.

1.9.5 Chapter 5 Findings: Being-Present, Being-With, Transformation

Chapter Five explores the three themes that emerged from the GEN student participant interviews to answer the research questions: **How do Graduate Entry Nursing students in Aotearoa New Zealand experience the development of empathy in clinical practice?** This chapter shares the stories of GEN student participants by using direct quotes from the interview transcripts to explain and justify my interpretation of their shared experiences from clinical practice settings.

1.9.6 Chapter 6: Discussion and Conclusion

Chapter Six provides a discussion between the research findings and the extant literature. This chapter describes the importance of the research findings and their implications for clinical practice, education, and research. The strengths and limitations of this study are explained, and recommendations for future research are made. The final part of this chapter contains a conclusion and a personal reflection on this journey.

1.10 Summary

This introductory chapter has set the scene for what will follow in the rest of this thesis, by introducing the research and justifying the rationale for the chosen research question. This qualitative hermeneutic phenomenological exploration examines the lived experiences of GEN students' empathy development in clinical practice. Narration and storytelling, both of which are integral to science and research, contribute to nursing research and the methodology of this study. Empathy, interwoven with storytelling, is crucial in understanding and connecting with others. The chapter has delved into my own journey of how I came to this research, navigating the blend of art and science in nursing, culminating in a focus on qualitative research to explore empathy. The choice to study GEN students comes from identifying the noticeable gap in research between this cohort of nursing students and empathy development. The significance of this is that the development of empathy in GEN students is unexplored, to my knowledge, in Aotearoa New Zealand. As a profession evolving beyond academic achievements, nursing requires qualities like empathy for better health outcomes. For

this study, empathy has been defined as the cognitive recognition and perception of another's needs, effectively felt and communicated, which fosters an emotionally safe environment. The aims centre on understanding the lived experience of empathy development in GEN students, addressing a literature gap and informing educational strategies. The overview of the chapters outlines the trajectory of the thesis and the research journey, a fusion of personal curiosity, dedication to nursing education, and a commitment to producing work that directly influences positive systemic changes in the nursing profession.

In the next chapter, I present the literature review I undertook to explore the key concepts central to this study. I outline the process of the literature review, including the databases used and the search strategies. The chapter then unpacks the key concepts, drawing on literature to support and contextualise them.

Chapter 2 Journey through the Literature

"Empathy fuels connection", Dr Brené Brown, 2018, p. 140

2.1 Introduction

This chapter presents the literature review that informed and shaped this study. A well-considered piece of research is informed by reviewing the existing literature, identifying what is known, and what is not yet understood (Snyder, 2019). In this case, I sought to explore literature relating to the three interconnected concepts of the research question: **How do Graduate Entry Nursing (GEN) students in Aotearoa New Zealand experience the development of empathy in clinical practice?** The three concepts were: empathy, GEN students and clinical practice. To me, this process of reviewing the literature felt metaphorically as though I more as through I was sifting for gold – sifting through layers of content, removing what was irrelevant and holding onto the small but significant pieces of 'gold' that emerged. I found many articles that explored nursing students in undergraduate bachelor's degrees and the concept of empathy. However, I could not locate any literature or research articles that dove into exploring the lived experience of GEN students in developing empathy; however, empathy is a fundamental nursing attribute for all nurses.

The opening quote of this chapter is one by Dr Brené Brown. This quote fits well to begin this chapter, as I sought to make connections between the existing literature and the key concepts of this study. I have chosen to place this quote at the start of the literature review for two reasons. Firstly, the prospect of undertaking a literature review felt intimidating. This was due to an initial lack of understanding and uncertainty of what I would find in the literature. I have now come to understand that this process is like placing the initial piece of a large jigsaw puzzle. This process is a slow and methodical process. I have needed to identify and appreciate all the pieces, but I continue to sift through them to find ones that fit. To me, looking at this as a giant jigsaw symbolises connection. I needed to connect literature, concepts, ideas, thoughts, and research together to make sense of it as a whole. Paré and Kitsiou (2017) call this synthesising information. The second reason is that during this process, I felt I needed to be more empathetic to myself. I needed to allow this empathetic drive to fuel me through this

process of connecting the pieces. Empathy can act as a metaphorical bridge between people, connecting them (Brown, 2018). It is necessary for emotional health and is central to care in clinical settings (Moudatsou, et al., 2020).

In line with interpretive studies, such as hermeneutic phenomenological studies, I approached the literature as someone who has ‘fore-understandings’ of the concepts (Heidegger, 1962). These are the assumptions and lived experiences that inform how individuals interpret the world (Heidegger, 1962). Heidegger, (1962) considers these 'fore' understandings essential for interpreting research. Throughout the literature review process, I was presented with research, themes, concepts, and definitions that required understanding and interpretation. This literature review is, therefore, the first step in the research journey as I embark on my 'fore' understanding of the key concepts. It is an initial step grounded in interpretation, curiosity, and connection.

I have broken this chapter into two parts. Part one discusses the steps that I took to find the relevant literature. Part two discusses the findings from the relevant literature.

Part One

When I began this review, my primary focus was to ascertain the body of knowledge around the phenomena and the experience of empathy development for nursing students in clinical practice. The overarching question I was trying to answer in this inquiry was, "What literature exists, and what insights does it offer regarding empathy development among GEN students in clinical settings?". Recognising the depth and breadth of this question, I explored various methods of systematically reviewing literature as I suspected I might be inundated by literature and uncertain about how to synthesise the search results.

I wanted to be systematic in my approach to reviewing the literature; however, utilising a systematic review proposal would not be suitable for a broad question like mine. I found that scoping reviews, like systematic reviews, help researchers address broader research questions, such as the one under discussion in this study (Peters et al., 2020). Scoping reviews follow a similar philosophy to systematic reviews, but they synthesise existing evidence on a research question topic(s) following rigorous and

systematic searches on selected databases (Peters et al., 2020). Scoping reviews act as maps or navigational pathways to provide an overview of evidence, concepts, or studies developed in a specific field (Peters et al., 2020). Scoping reviews can help researchers to clarify key question topics and help define key concepts by identifying common characteristics and factors related to those concepts (Peters et al., 2020). Furthermore, scoping reviews can help researchers identify gaps in the existing literature, which aids in the development of new research and the filling of these gaps. Ultimately, I decided to follow a scoping review approach due to its suitability, given the broad nature of the research question and its alignment with the typical characteristics of scoping reviews (Aromataris et al., 2024). I followed the 'Arksey and O'Malley Scoping Review Framework' (2005), which has five steps: (1) identifying the population, concepts, and context (PCC); (2) identifying relevant studies; (3) selecting studies; (4) charting the data; (5) summarising and reporting the results.

2.2 Identifying Questions

The initial, very broad question guiding this inquiry was, "What literature exists, and what insights does it offer regarding empathy development among GEN students in clinical practice settings?" However, I acknowledged this question was too large and non-specific for the focused literature review. To refine this, I asked myself:

(1) What aspects of empathy development amongst nursing students have already been explored?
(2) What areas require further investigation?
(3) What research methods have been used, and which could be most effective in future studies?

Following this reflection, I first refined the overarching research question to "How do GEN students experience the development of empathy in clinical practice?", removing the specific geographical location. Later, I broadened the question to include all nursing students, both undergraduate and postgraduate GEN students, and simplified the question to: "How do nursing students develop empathy in clinical practice?"

The rationale for this step was guided by the population (P), concept (C) and context (C) (PCC) framework, as outlined in Arksey and O'Malley's five-stage Framework for

Scoping Reviews (Arksey & O'Malley, 2005). By aligning my question to this framework, I sought to ensure clarity and precision in defining the scope of my inquiry. Defining the population (nursing students), concept (empathy development) and context (clinical practice) helped focus the review and establish clear boundaries, which laid the foundation for a rigorous and systematic exploration of the literature on empathy development in nursing education.

Table 2. Population, Concept, and Context (PCC).

PCC	Definition
(P) Population	Nursing students enrolled in nursing programmes leading to professional registration, regardless of sex, nationality, age and geographic location.
(C) Concept	Empathy development, including cultivation, education interventions, and outcomes related to nursing practice.
(C) Context	Clinical practice settings where students are exposed to real-life nursing care alongside RNs and patients.

2.3 Preliminary Search Methods

The preliminary search began in February 2024, adopting a broad approach informed by the PCC framework to gain an initial understanding of the existing literature. General search terms based on the key concept's 'empathy', AND 'student nurse', AND 'clinical practice'. The purpose of this search was to get a 'feel' of what literature already existed (Cooper et al., 2018). The database used was the Cumulative Index of Nursing and Allied Health Literature (CINAHL) via EBSCOhost, with a language limit of English to ensure accessibility and manageability. This search yielded 80 results, which provided me with a foundational overview of existing research related to empathy development, nursing students and clinical practice.

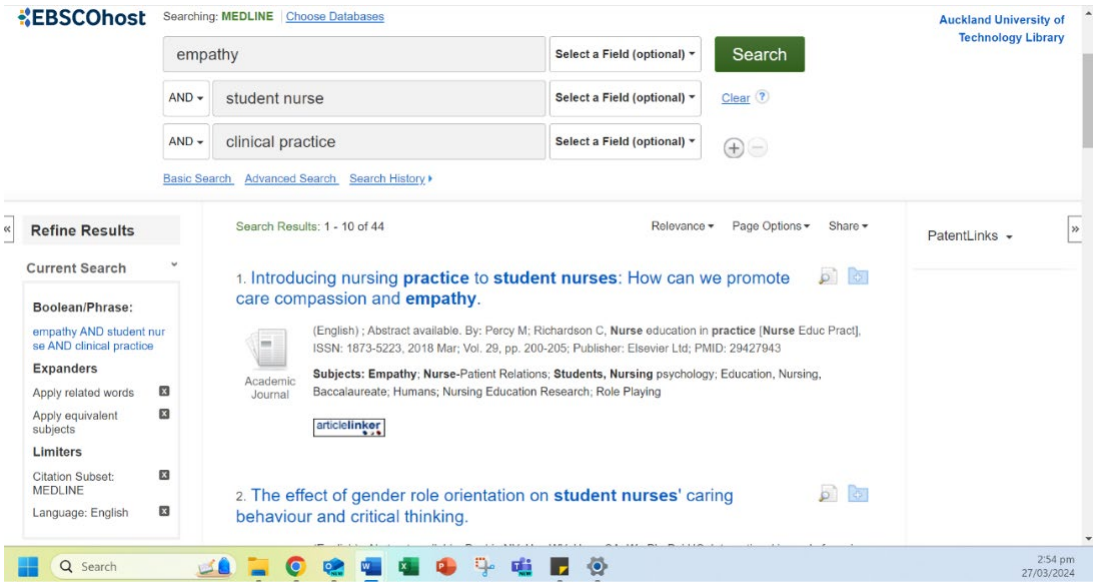
Figure 4

Screenshot of search results from CINAHL, March 27th, 2024

After searching on the CINAHL database, I moved to the MEDLINE database via EBSCOhost, using the same keywords and limits. This search yielded a total of 44 results.

Figure 5

Screenshot of search results from MEDLINE, March 27th, 2024



2.4 Comprehensive Search Phase

Following the decision to conduct a scoping review, I decided to expand the search strategy. The rationale for this step was to capture a broader range of articles and increase the volume of relevant literature for review. I extended the use of databases to

include Scopus, MEDLINE and Cochrane alongside CINAHL. This process enabled me to identify more relevant subject headings and keywords, which further refined the search strategy. This approach aligned with the second step in Arksey and O'Malley's Five-stage Framework for Scoping Reviews (Arksey & O'Malley, 2005). Boolean operators of 'AND' and 'OR' were used to logically combine search terms. Table 3 below details the databases, search terms, and limits applied during the search process.

Table 3. Search Strategy: Databases, Search terms, Boolean operators, and Limits.

Database	**Search term 1 (AND)**	**Search term 2 (AND)**	**Search term 3 (AND)**	**Search Limits**
CINAHL, MEDLINE, Scopus, Cochrane	empath* OR compassion* OR "interpersonal skill*" OR "therapeutic communication" OR " therapeutic relationship" OR "soft skills" OR "therapeutic presence" OR "emotional cue*"	"nursing student" OR "student nurse"	"clinical practice" OR placement* OR "clinical experience" OR “clinical placement” OR "clinical environment*"	Published in the English Language, Date range from 1970-2024, Abstract available

CINAHL, Cumulative Index of Nursing and Allied Health Literature

Note: The same search terms and Boolean operators were applied across all databases with consistent search limits.

The date range (1970-2024) was deliberately broad. The rationale for this was to capture all relevant literature regarding the development of empathy and GEN students since the first GEN programme was established in the United States of America in the 1970s in response to nursing workforce shortages (Macdiarmid et al., 2021). This justified extending the date range back to the 1970s to maximise the retrieval of relevant studies on empathy development in GEN students. The comprehensive search yielded a total of 481 articles. 177 duplicates were detected and removed, leaving 304 articles to screen and review.

Part Two

The following section provides a comprehensive synthesis of the literature concerning GEN students, nursing students more broadly, empathy development, clinical practice

and the associated key themes. This section draws on current research and aims to unpack the existing knowledge around the central concepts. To establish context, this discussion begins by outlining an overview of nursing education in Aotearoa New Zealand.

2.5 Nursing Education in Aotearoa New Zealand

As discussed in chapter one, following the transition of nursing education to the tertiary sector, registration as a nurse in Aotearoa New Zealand required completion of an undergraduate degree, which is approved by the Nursing Council of New Zealand (NCNZ) (Jamieson et al., 2020). In Aotearoa New Zealand, the NCNZ oversees nursing education and standards and accredits educational institutes (NCNZ, 2024). According to the NCNZ, all nursing students must complete 1000 hours of clinical practice experience by the end of their educational programs (NCNZ, 2022). Graduates then become eligible to sit for the NCNZ State Examination, and upon passing, can register and gain employment as an RN (NCNZ, 2023, 2022). In 2014, the NCNZ approved an accelerated and intense two-year pathway to nursing registration, known as the Graduate Entry to Nursing (GEN) programme (Jamieson et al., 2020). This pathway enables graduates of other disciplines to become RNs and gain a master's degree (Jamieson et al., 2020; Winnington et al., 2023). Unlike the Master of Nursing programme, which advances current RNs' expertise, the GEN programme offers foundational nursing education for those entering the profession (University of Auckland, n.d.-a).

The GEN Programme is a pre-registration degree (Auckland University of Technology, n.d.-b; University of Auckland, n.d.-b). Although the GEN programme is relatively new in Aotearoa New Zealand, it commenced in the United States in the 1970s to address workforce demands (Usher, 2006; Macdiarmid et al., 2021; Neill, 2012). The GEN pathway has since commenced in Australia and Aotearoa New Zealand as an alternative pathway for graduates to become RNs (Usher, 2006; Macdiarmid et al., 2021; Neill, 2012). Today, seven tertiary institutions offer GEN programmes in Aotearoa New Zealand, facilitating greater availability and accessibility for students considering this master's degree and a career in nursing (NCNZ, 2022). The undergraduate degree, however, remains the highest contributor of nursing graduates to Aotearoa New Zealand's nursing workforce (Willis, 2021).

An admission prerequisite for the GEN programme is the completion of an undergraduate degree (Auckland University of Technology, n.d.-b; University of Auckland, n.d.-b); Otago University, n.d.). Tertiary institutes offering GEN programmes in Aotearoa New Zealand have varied admission requirements regarding the type of undergraduate degree awarded to the applicant. For example, some tertiary institutes require the GEN student applicant to have a health-related undergraduate degree, such as midwifery, psychology, occupational health, etc. (Auckland University of Technology, n.d.-b; University of Auckland, n.d.-b); Otago University, n.d.). Other tertiary institutes simply require the applicant to have completed an undergraduate degree, from any field of study (Auckland University of Technology, n.d.-b; University of Auckland, n.d.-b); Otago University, n.d.). This, too, contributes to a diverse workforce of RNs working in Aotearoa New Zealand, with two avenues available at tertiary institutions leading to professional RN registration (Macdiarmid et al., 2021), and one that specifically caters to students who have a previous life and tertiary education experience in the profession.

2.6 Background on GEN Students

Building on the overview of nursing education in Aotearoa New Zealand, this section explores the characteristics of GEN students. The GEN student cohort is distinct in that they enter GEN programmes with prior tertiary education and a wide range of life experiences, which differentiates them from the traditional undergraduate nursing students (Jamieson et al., 2020; Shannon et al., 2023). As GEN students have already completed a tertiary degree, which usually takes three or four years to complete, they are typically older than the undergraduate nursing student cohort, who traditionally attend tertiary institutes for further education straight out of school (Jamieson et al., 2020; Downey & Asselin, 2015; Shannon et al., 2024). The New Zealand Nurses Organisation (NZNO) National Nursing Student Survey 2021 reports that 40% of student nurses in Aotearoa are aged 18 – 21, which reflects the younger cohort of nursing students in the undergraduate nursing student cohort (Willis, 2021).

Motivations for enrolling in a GEN programme vary by individual and context. Studies show that one of the main reasons GEN students choose to change careers and enter nursing later in life is the desire for a more meaningful and rewarding profession (Macdiarmid et al., 2021b). One that allows them to help others and make a positive

impact through compassion and care (Macdiarmid et al., 2021b). “GEN programmes are an alternative and intensive pathway into the nursing profession that attracts applicants seeking a change in career or a more fulfilling work role.” (Shannon et al., 2024, p.77). The accelerated two-year structure appeals to many by allowing for a quicker career change and reducing the financial burden of prolonged full-time study (Shannon et al., 2024). Macdiarmid et al. (2021a) also suggest that the opportunity to gain a nursing education with a more mature student cohort and to complete a programme that may offer faster career advancement is a key motivator for some students.

GEN students often engage more effectively with the taught academic content due to their previous educational and life experiences (Winnington et al., 2023). Students also tend to bring valuable transferable skills that contribute to their success in these programmes, such as supportive peer networks (Shannon et al., 2024). However, some studies do caution that the nature of these accelerated programmes positions GEN students with limited time for the adaptation and development of critical thinking and other essential nursing competencies (Bowie & Carr, 2013). Moreover, some GEN students can encounter negative perceptions from RNs in clinical practice, who may view them as overly academic (Aubeeluck et al., 2016). Even the media has a part to play in this, with studies suggesting the media can portray educated nurses, such as GEN students, as “too posh to wash” (Aubeeluck et al., 2016, p. 104). These attitudes and comments can undermine student confidence, making their clinical experiences challenging (Aubeeluck et al., 2016).

The educational journey for GEN students is both complex and unique. Complex, in how they experience different challenges, from perceptions of RNs in clinical practice, to the intensity of an accelerated two-year degree, and their own unique experiences (Shannon et al., 2024). Unique in the way that this cohort of nursing students brings prior academic achievement, life experience, and a more mature perspective to nursing education, which contrasts those entering the profession through the traditional undergraduate pathways (Shannon et al., 2024). Research by Shannon et al. (2024) explains that GEN students can feel vulnerable, unsure, and stressed at times during their nursing education. Research also shows that GEN students tend to perceive themselves as bringing different qualities to the programme, such as resilience, when compared with undergraduate nursing students (Shannon et al., 2024; Stacey et al.,

2018). Again, this shows how this cohort of nursing students is unique and, as literature suggests, positions itself as advantageous (Aubeeluck et al., 2016).

2.7 GEN Programme and Empathy Development

Literature exists that speaks to the disadvantages of developing essential nursing skills in an accelerated programme. A systematic review by Doggrell and Schaffer (2016) indicates high attrition rates in students who undertook their nursing education in an accelerated programme; however, research also demonstrates that accelerated nursing programmes often result in increased stress and burnout in students, when compared to students in traditional nursing pathways (Hegge & Larson, 2008; Roberts et al., 2001). Compressed curriculum in accelerated nursing programmes places high demands on students in terms of adaptability and time management, which may exceed the students' coping capacities (Hegge & Larson, 2008). When studies have investigated the mental health of students in bachelor programmes compared to GEN programmes, there tends to be more diagnosed mental health conditions and cited academic pressure from students in accelerated pathways (Owen & Pfeiffer, 2023). Studies have shown that chronic stress impairs cognitive engagement and reflection, both of which are necessary for the development and responsiveness of empathic care (Girotti et al., 2024; Hajibabaee et al., 2018). Without time for reflection and relational interactions during clinical settings, it is more challenging for students to form meaningful connections with patients (Alsalamah et al., 2022).

Students in accelerated nursing pathways, who experience intense pressure to perform, may become more task-oriented in clinical practice settings and emotionally detached, which impedes the development of empathy (Flarity et al., 2013; Yu & Kirk, 2009). These findings suggest that while accelerated nursing programmes offer a rapid entry into the nursing profession, their demanding structure may compromise the development and cultivation of fundamental nursing qualities such as empathy. High stress levels and limited time for reflection, may cause detached patient interactions and risk producing graduates who lack emotional readiness for practice. This demonstrates the need for nursing educators, tertiary education institutes, and clinical placement environments to consider how an accelerated programme design may impact emotional readiness for practice. However, as mentioned earlier, higher levels

of emotional intelligence are correlated with coping with stress related to higher education (Xu et al., 2023). Therefore, developing empathy and emotional intelligence will assist students in learning to manage their stress related to studying at a tertiary institute (Xu et al., 2023), and particularly in an accelerated programme.

2.8 Clinical Practice Settings

Andragogy, teaching adult learners, emphasises self-direction, practical experience, and problem-solving (Mukhalalati & Taylor, 2019). Andragogy is used in nursing as it is a unique blend of art and science approaches to helping adults learn (Mukhalalati & Taylor, 2019). One way of supporting this learning in nursing programmes is through the clinical practice learning required by the NCNZ (2022). The clinical placement component of nursing education in Aotearoa New Zealand is designed to equip students with the necessary qualities and experiences to become competent nurses upon graduation (NCNZ, 2022). The NCNZ requires all nursing students, regardless of their chosen nursing education pathway, to complete a minimum of 1000 hours of clinical practice to ensure they are well-prepared for the State Examination and their future roles within the healthcare system NCNZ, 2022).

In clinical practice settings, students participate in the care of patients and are part of the wider healthcare team, which enables them to apply the knowledge they have learned to practice (Matchim & Kongsuwan, 2015). The clinical setting locations are diverse to ensure students are exposed to a wide range of healthcare environments, thereby enhancing their learning and understanding of the complex and broad healthcare system in Aotearoa New Zealand. The duration of the clinical placements varies from a few weeks to several months, depending on the educational institute's curriculum and the requirements of the clinical area. A study by Matchim and Kongsuwan (2015) states that real-life, hands-on practice integrates theory and practice, which helps develop mental strength as students experience success and failure, which leads to reflective practice. Reflective practice "… empowers nursing students to critically analyse complex healthcare scenarios, make evidence-based decisions within their professional domain, and implement effective interventions both independently and as part of multidisciplinary teams" (El Atmani, 2025, p. 29).

By working in diverse clinical settings and under the guidance of experienced professionals, nursing students gain invaluable hands-on experience that enhances their theoretical knowledge and prepares them for the complexities of the nursing profession. Students continually learn, relearn, adjust, correct, and refine their clinical skills while in these clinical settings. Hard skills, what students know and do, such as taking vital signs (blood pressure, temperature, respiratory rate, heart rate, and oxygen saturation, pain), administering medications under supervision of RNs, performing wound care, assisting with daily living activities, following infection control procedures, accurate documentation, recognising and escalating changes appropriately (Song et al., 2022). Soft skills include self-reflection, effective communication with patients, their whānau, and the healthcare team, as well as acting with empathy and demonstrating dignity and respect, and applying clinical reasoning during assessments and interventions (Song et al., 2024). This does not encompass the exhaustive list of clinical skills that students develop during their educational journey and in clinical practice.

These hands-on, real-life experiences help students build technical competence and confidence, as well as critical thinking and adaptability in real-world settings (Betti et al., 2022). Finding a balance between developing competence in both hard and soft skills can be challenging. Hard skills in nursing tend to be directly aligned with tangible outcomes, whereas soft skills have less immediate tangible outcomes. Song et al. (2024) discuss how a lack of objective assessment tools in measuring the effectiveness of soft skills makes it difficult for nurses and student nurses to recognise the importance of soft skills in clinical practice. However, soft skills are important in nursing practice. A study by Purabdollah et al. (2024) shows that reflection and debriefing in clinical placements can promote self-awareness, empathy, and professional growth in nursing students. Reflection is, therefore, a process that can help students develop soft skills, such as empathy (Purabdollah et al., 2024).

2.9 Background on Empathy

Empathy is a complex quality that involves understanding the lived experience of another and providing a safe environment for them to share their moods, feelings and emotions (Levett-Jones et al., 2019; Moudatsou et al., 2020). It involves drawing on one's own experience of having felt emotions and moods, and an ‘empathetic

imagination' (Kaldal et al., 2018). Kaldal et al. (2018) describe 'empathetic imagination' as the ability to imagine what it would feel like to be in another's situation based on their own lived experiences in the world (Kaldal et al., 2018). To achieve this, one must employ the qualities of resilience, vulnerability, and effective communication, making empathy a comprehensive skill (Moudatsou et al., 2020). Empathy is said to have 'cognitive' and 'emotional' components (Al-Amer et al., 2022). The cognitive aspect allows a person to understand what others are feeling or thinking without becoming emotionally involved. At the same time, emotional empathy involves feeling what another person is experiencing on an emotional level (Al-Amer et al., 2022). Literature, therefore, suggests that empathy is not just a quality that someone is born with, but rather, it is an attribute that can be trained and developed over time (Riess, 2017).

Empathy can be further categorised as 'basic' (trait) and 'trained' (state) empathy (Alligood, 2005). Basic empathy is a trait that can be defined as "a human developmental feeling attribute of the person and environmental processes" (Alligood, 2005, p. 301). Basic empathy stems from innate personality traits. Trained empathy is a state of being that can be defined as the "transient behaviours enacted to convey an understanding of another person" (Alligood, 2005, p. 301). Trained empathy involves the development of skills like role-taking and clinical applications. Research demonstrates that trained empathy, often called 'clinical empathy', is a critical factor in delivering safe, individualised, high-quality care, which can lead to better patient outcomes (Halpern, 2003; Winter et al., 2022). Clinical empathy enables healthcare providers to assess patients more accurately, as it can lead to fostered relationships and shared understanding (Halpern, 2003; Winter et al., 2022).

2.10 Empathy, Compassion and Sympathy

Empathy, sympathy, and compassion are closely related terms that have been used interchangeably within healthcare policy and research (Sinclair et al., 2016). However, these terms are not the same and therefore should not be used interchangeably. For this reason, I have conducted a review of the three concepts to differentiate them for the purpose of my own understanding.

Riess (2017) explains that empathy can be characterised as an interpersonal and societal skill that enables a human connection through the sharing of experiences,

needs, and desires of individuals. Empathy in this sense could be understood as an emotional bridge that enables us to perceive the feelings, thoughts and emotions of others (Riess, 2017). Empathy can be viewed as a process of imagining the thoughts, feelings, and emotions of others as a way of sharing their experience (Jacobsen, 2024). If skilfully executed, the desired result of empathy should be an ability to resonate with others on an emotional and cognitive level, to understand their perspectives, and to recognise the difference between our own and others' emotions (Riess, 2017). This is to say, to act empathetically, one does not embody the thoughts, feelings and emotions of another, but rather they sit in a deep understanding of these (Riess, 2017). To explain further, Dr Brené Brown, a shame researcher from the University of Houston, writes in her book 'Dare to Lead' ", Empathy is not connecting to an experience. Empathy is connecting to the emotions that underpin an experience" (Brown, 2018, p. 140). It is the emotions, thoughts, feelings, moods and beliefs of another that are needed to relate to in empathetic care (Sinclair et al., 2016).

Closely situated to empathy is compassion. Empathy is closely situated to compassion as it is embedded *within* compassion. Compassion is a concept that needs to be understood to understand the role of empathy as a nursing graduate attribute (Eklund et al., 2019; Sanderson & Brewer, 2017; Sinclair et al., 2016). Compassion is a concept that enhances "the key facets of empathy while adding distinct features of being motivated by love, the altruistic role of the responder, action, and small, supererogatory acts of kindness" (Sinclair et al., 2016, p. 437). Sinclair et al. (2016) explain that to be compassionate, one must embody empathy, meaning that empathy is a prerequisite and requirement of compassion. "… compassion we draw from wholeness of our experience – our suffering, our empathy, as well as our cruelty and terror" (Chödrön, 2001, p. 91). This quote by American Buddhist nun, Pema Chödrön, from her book 'The Places that Scare You' demonstrates that compassion requires lived experiences of pain, suffering, and hurt to be able to connect with another's experience. Moreover, compassion can be described as a feeling that arises in witnessing the suffering of another (McConnell et al., 2024).

Compassion, therefore, differs from empathy as empathy is about *connecting with the emotion underlying an experience*, and compassion is about *connecting with another's experience, based on our own experience* (Brown, 2018; McConnell et al.,

2024). Moreover, empathy reflects our ability to connect with the emotion(s) *of* an experience. Compassion reflects our ability to connect our lived experience to that of another, requiring us to seek empathy for their experience (Sinclair et al., 2016). A study by McConnell et al. (2024) explains that empathy is widely experienced as part of a process used to cultivate compassion. Through this lens, empathy can be understood as a prerequisite for compassion rather than a separate term or concept that can be used interchangeably or as a term that can be used to replace empathy.

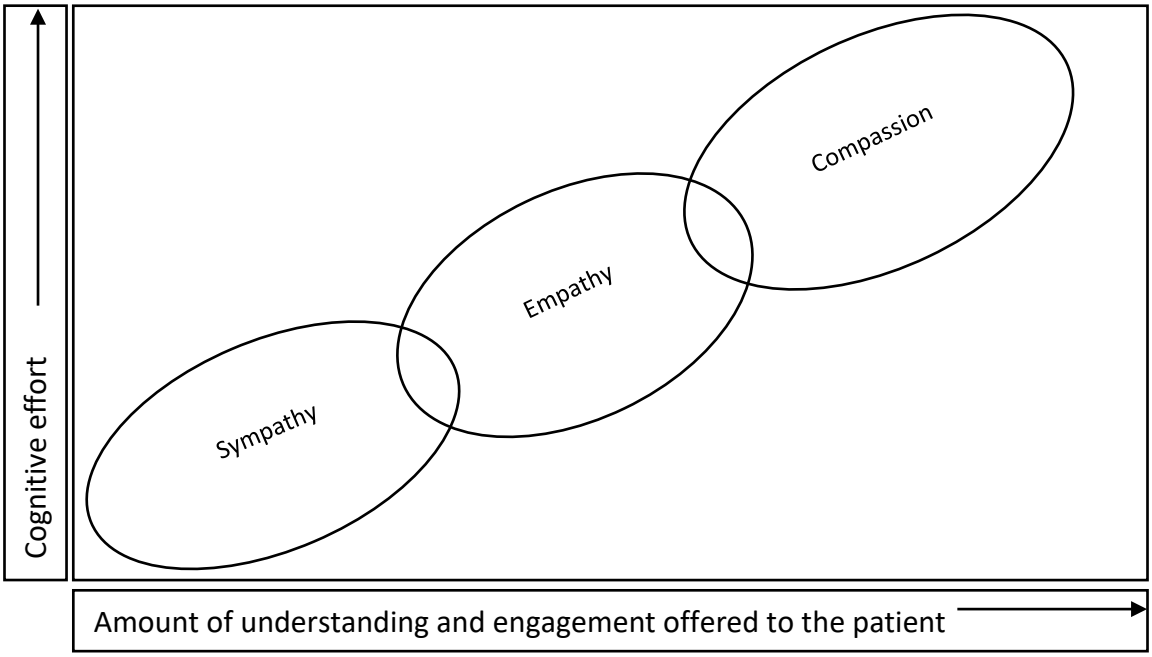
The concept of sympathy has an essential distinction from empathy in clinical practice. Empathy and sympathy have significantly different clinical outcomes for patients and come from different places of connection (Sinclair et al., 2016). Sympathy is an emotional reaction to a patient's pain, suffering, main concerns, or needs, and is associated with less optimal health outcomes for patients than empathy (Hojat et al., 2018; Sinclair et al., 2016). Empathy is a cognitive response and awareness of the patients' situation (Sinclair et al., 2016). Sympathy is seen as a reactive response to the emotions of another, rather than cognitive, due to the amount of effort required to make an impact or level of connection with another in sympathy (Sinclair et al., 2016). Sinclair et al. (2016) say the amount of effort, energy, and time required to be sympathetic towards another is much less than that of empathy or compassion, resulting in a less-than-optimal outcome for the patient and their emotional well-being.

Understanding the nuanced distinctions between compassion, empathy, and sympathy was an essential part of the literature review. I needed to understand the distinctions between the three concepts in order to accurately frame the concept of empathy as it relates to nursing education and clinical practice. Sinclair et al. (2016) explain that these three terms are often used interchangeably in literature, which can lead to conceptual ambiguity and misapplication in nursing practice. For this reason, I included this section in the literature review to clarify the defining features of each concept and show how empathy is distinct yet interrelated with compassion and sympathy, given that empathy is a graduate attribute for nurses that is crucial to fostering therapeutic, professional relationships (Eklund et al., 2019; Sanderson & Brewer, 2017). I saw a need to explore and understand these concepts as part of my 'fore-understandings' before exploring how GEN students experience the development of empathy to avoid conflating similar, but certainly distinct, concepts. Below (Figure 6)

is a diagram I created to differentiate sympathy, empathy, and compassion, as I now understand them. It shows they are different, but that there is some overlap.

Figure 6

Cognitive effort, understanding, and engagement are required for sympathy, empathy, and compassion.



2.11 Empathy in Nursing

Tan and Caleon (2022) argue that nursing is a profession where success extends beyond academic achievements. Upon graduating, nurses are expected to embody qualities that place them in desirable positions for delivering optimal health outcomes (Tan & Caleon, 2022). There is evidence to suggest that nurses who embody empathy are more likely to provide better health outcomes to their patients (Brunero et al., 2022; Levett-Jones et al., 2019). Empathy has been well cited in literature as a fundamental nursing skill, as it facilitates a safe patient-nurse relationship and improves health outcomes (Moudatsou et al., 2020). Empathy, as cited by Levett-Jones et al. (2019) and López-Martínez et al. (2023), is said to involve the cognitive recognition of another's needs and the emotional ability to perceive, feel, and communicate that need in a way that promotes a safe and supported environment. An empathetic nurse shares the thoughts of those whom they are caring for and, in doing so, builds a patient-nurse relationship (Eklund et al., 2019; Gazwani et al., 2023). Empathy as a concept underpins aspects of the emotional work that nurses and healthcare professionals undertake in their daily

professional roles and responsibilities (Burgess et al., 2022). Nursing practice involves constant engagement and communication with others, often bringing out a wide range of positive and negative emotions, which, for nursing students, can be challenging as they begin learning to manage these emotions (Al-Amer et al., 2022). Research by Cilar et al. (2020) suggests that nurses need high levels of emotional intelligence and empathy due to the nature of their daily interactions with people in clinical environments to provide optimal care to patients and their whānau (family). Therefore, nursing students are expected to show interest and a keen desire to work with people during their nursing studies and begin to develop soft skills, in addition to hard skills (Cilar et al., 2020).

Resilience, vulnerability, and effective communication are integral to nursing success and conveying empathy (Tan & Caleon, 2022). Resilience can be described as one's ability to bounce back from adversity, and vulnerability can be described as one's ability to embrace uncertainty and discomfort and to lean into situations of connection and risk (Aryuwat et al., 2023; Kaldal et al., 2018). Nurses must be empathetic to foster therapeutic relations and promote optimal health outcomes, but this too requires the ability to be vulnerable and resilient. There are, however, arguments against empathy being an appropriate attribute for nurses. Beauvais et al. (2017) and Hunt et al. (2019) report that environments where high amounts of empathy and empathetic care are required can lead to clinical burnout, also known as compassion fatigue, among RNs. Burnout, as described by the World Health Organisation (WHO) (2019), is an occupational phenomenon that results from chronic workplace stress that has not been successfully managed. The WHO (2019) describes burnout by the following three characteristics:

- Feelings of exhaustion or the depletion of energy,
- Increased mental distance from the individual's job, and/or feeling pessimistic or cynical towards one's job; and,
- A reduced professional efficacy at work.

Beauvais et al. (2017) said that the greater the nurses' emotional intelligence and the greater empathy they showed towards positive emotions, the less clinical burnout they saw in their participant group from their clinical study. However, Hunt et al. (2019) explain that in areas of high empathy and compassionate care, such as areas where

nurses work with patients with cancer, the risk of compassion fatigue is greater. Education that focuses on regulating emotions may help student nurses manage the emotional demands of their work and the emotional stress they may experience (Cao et al., 2021). When nurses are feeling emotional stress for a long period of time, they are less empathetic in their care, and this feeling may lead to compassion fatigue (Hunt et al., 2019). However, if nurses and student nurses receive education on how to manage emotions and develop effective strategies to increase empathy and resilience, burnout may be reduced (Cavanagh et al., 2020; Cao et al., 2021). This quote by Brown (2021) explains the importance of setting boundaries between oneself and another person when providing care, especially empathetic care:

> "Boundaries are a prerequisite for compassion and empathy. We can't connect with someone unless we're clear about where we end and where they begin. If there is not autonomy between people, then there is no compassion or empathy, just enmeshment" (Brown, 2021, p. 115).

A boundary or 'boundaries' is a metaphorical term that describes systems that isolate and define a line where an individual ends and another begins (McDaniel et al., 2021). Within health, boundaries are particularly critical to providing optimal patient care, as research suggests that health professionals who have isolated and defined boundaries can provide stability, structure and emotional safety (McDaniel et al., 2021). Ethically, health professionals are expected to maintain strict professional boundaries, where the relationships and interactions with others are strictly professional (NCNZ 2019; NCNZ, n.d.-b). If executed correctly, setting professional boundaries can create a space for empathetic care, thereby reducing clinical burnout due to emotional workplace stress (Brown, 2021).

2.12 Empathy and GEN Students in Aotearoa New Zealand

Although GEN programmes have existed internationally since the 1970s (Macdiarmid et al., 2021), the literature review confirms that there is limited research exploring the development of soft skills among GEN students. To my knowledge, there are no studies exploring empathy development in GEN students. Despite this gap in the existing literature, the NCNZ expects graduate nursing students to be empathetic in their nursing practice. The NCNZ recognises that soft skills are an essential component of being an RN

and “For care to be effective, collaborative and compassionate, relationships based on trust, partnership and acceptance of diversity are fundamental” (NCNZ, 2025 February, p.4).

The NCNZ is required to establish and set standards of competencies for RNs in Aotearoa New Zealand, under the HPCAA 2003 (n.d.) (NCNZ, 2025). The standards of competencies were established for RNs to demonstrate they are and continue to be competent in their nursing practice (NCNZ, 2025). Tertiary institutes that offer nursing programmes in Aotearoa New Zealand are audited by NCNZ to ensure their programmes are set up to ensure students' progress towards and meet the Standards of Competencies for Registered Nurses upon completion of their degree. There are six pou (standards) for RNs in the set Standards of Competence (NCNZ, 2025). One relates to empathetic and compassionate care. Pou five:

> *Pou five: Manaakitanga and people-centred care requires nurses to demonstrate compassion, collaboration and partnership to build trust and shared understanding between the nurse and people, whānau or communities. Compassion, trust and partnership underpin effective decision-making in the provision of care to support the integration of beliefs and preferences of people and their whānau.* (NCNZ, 2025, p.4).

The NCNZ recognises that nurses and nursing care require compassionate care to build shared understanding (NCNZ, 2025). Empathy is known for being a graduate attribute, but compassion is an essential standard of competency for RNs in Aotearoa New Zealand (Eklund et al., 2019; Sanderson & Brewer, 2017; NCNZ, 2025 February). As empathy is a prerequisite for compassion, it is important for students to develop empathy during their nursing education (Riess, 2017; Arman, 2023).

2.13 Empathy and Undergraduate Nursing Students

What is known from the existing literature is that undergraduate nursing students are vulnerable and continue to be vulnerable throughout their entire journey to becoming health professionals (Heggestad et al., 2022). Moreover, this level of vulnerability extends to developing skills such as empathy (Heggestad et al., 2022). Research suggests that a complex interaction between formal and hidden curricula is embedded in undergraduate student nurses’ programmes. The role modelling of empathy in clinical

practice is essential in developing such professional skills (Baldwin et al., 2014; Heggestad et al., 2022). However, there are factors, such as self-consciousness, that may affect students' ability to be empathetic (Lee et al., 2023).

Eklund et al. (2019) found that student nurses have varying empathetic tendencies across different stages of their educational training. Student nurses can struggle to develop the skill of empathy, with research by Kaur et al. (2018) suggesting only 30% of nursing students demonstrate empathetic traits towards those they care for. Despite its complexities, empathy is a skill that can be and needs to be taught as it is a fundamental graduate attribute for nurses (Eklund et al., 2019; Sanderson & Brewer, 2017). Research findings from studies examining undergraduate nursing students and empathy conclude with statements suggesting educational clinical training should include empathy development in the nursing curriculum (Sürücü et al., 2021).

2.14 Empathy and Nursing Education

Research suggests that undergraduate student nurses often hold idealistic perceptions of nurses as caring, compassionate, and empathetic health professionals (Allen et al., 2022). However, Allen et al. (2022) then goes on to explain that despite these idealistic perceptions, students frequently report feeling naïve or unprepared when it comes to demonstrating empathy in clinical settings. The naivety of the undergraduate nursing students appears to be the result of inadequate education preparation for clinical practice, along with the unintentional suppression of empathy development by academic staff (Allen et al., 2022; López-Martínez et al., 2023). Nursing education is said to pay more attention to the development of hard nursing skills and focuses less on the development of soft nursing skills (Ernawati & Bratajaya, 2021; Moropa et al., 2025). Ernawati and Bratajaya, (2021) suggest that student nurses, as novices, need to be given the time and space to use both hard and soft skill attributes in their clinical practice. This is particularly important during the student nurses ‘adaptation phase, when nursing students move from being a novice to a beginner expert if they are to succeed in their future nursing careers (Benner, 1984; Ernawati & Bratajaya, 2021). However, a study by Moropa et al. (2025) suggested that the majority of the nursing educators (also known as clinical educators (CE)) in their study perceived teaching soft skills as a way to strengthen the personal capacity for interactions and relatability with others. Nurse

educators, or CEs, are RNs who can competently and comprehensively practice nursing independently, with accountability for their practice, and who may have additional qualifications in nursing practice/education (Moropa et al., 2025). Facilitating soft skills education and development in nursing education is essential for the preparation of nurse graduates, as it enables them to foster effective interpersonal interactions with patients and other health care professionals (Moropa et al., 2025).

Hays (2013) suggests that the act of storytelling by the CE to students is a means of teaching the concept of empathy. The storytelling brings about a sharing of experiences (Gidman, 2013; Schwartz & Abbott, 2007). Narration is seen as a method for deepening the relationship students have with themselves, patients, which increases the valuing of the lived experience of another, and strengthens the pātuitanga (partnership) of care (Gidman, 2013; NCNZ, n.d.-c; Schwartz & Abbott, 2007). Time for reflection and debriefing with CEs and nurse preceptors during the student's clinical placement experiences enables them to discuss and process some of the challenges they encounter during clinical practice (Purabdollah et al., 2024). As such, clinical empathy is crucial for honing clinical skills and vital for CEs, who should focus on teaching empathic approaches and their practical applications to enhance nursing practice rather than relying solely on inherent traits.

2.15 Reflection Point

When initially undertaking this literature review, I was confused by the interchangeable use of the terms ‘empathy’ and ‘compassion’ as they commonly appear in literature as nursing communication tools and graduate attributes. I knew I needed to understand the concepts to deepen my understanding of empathy, to be confident in my distinctions between the concepts, and to recognise when empathy was being employed versus when compassion was being employed. The more I read, the more my understanding developed, and distinctions appeared between the concepts that emerged. My understanding of the concepts of empathy and compassion has changed since undertaking this research. Whereas I previously understood that empathy and compassion were two distinctly different concepts used by health professionals. I now acknowledge that one cannot be compassionate without being empathetic. Empathy is a prerequisite for compassion (Riess, 2017; Arman, 2023). What I did not expect was the

need to define what sympathy is and how this differs from empathy. However, after reading about sympathy, I found it was essential to discuss it in the literature review to make a clear distinction between the three concepts of compassion, empathy and sympathy.

I now understand that sympathy reflects the listener's emotional response to the patient's experience that does not involve high levels of understanding or cognition. Being empathetic with another requires cognition and cognitive awareness, understanding and offers a connection *with* the emotion(s), mood(s) and feeling (s) *of* the experience. Being compassionate reflects the connection between the patient's experience and the empathetic understanding of that experience. Sympathy is an emotional response that does not attempt to connect with the other person or foster an emotionally supportive environment.

2.16 Summary

This chapter explained the key concepts for this study: empathy, clinical practice, and GEN students using literature to support the discussion. It is well documented that empathy is a key nursing attribute. The comprehensive literature review demonstrates that empathy and nursing students are well-researched areas of nursing education and clinical practice, particularly in terms of patient outcomes when empathy is used in clinical settings. However, upon reviewing the existing literature, I conclude that there are no studies that explore the relationship between GEN students and the development of empathy. This literature review supports the importance of this study by demonstrating the need for literature to include students with GEN and empathy development, as a noticeable gap exists.

In the next chapter, I will be discussing the methodological blueprint for this study, key philosophers, and the rationale for using hermeneutic phenomenology.

Chapter 3 The Methodological Blueprint

> "Science is fundamentally about people – the people who do science and the people who are affected by science" (Muindi, Ramachandran, & Tsai, 2020, p. 249)

3.1 Introduction

I chose this quote to introduce the methodological section of this study because it captures the essence of hermeneutic phenomenology, which centres on understanding human experience. I specifically enjoyed how this quote acknowledges more than just those who conduct or do science. In research, there is a relationship between the researcher, who interprets information, and the participants, who are interpreted (Muindi et al., 2020). It is a fluid relationship and captures this opening quote nicely. The opening quote sets the tone for the methodology used in this study, as I set out to value human experience, meaning-making and care.

In this chapter, I outline the philosophical and methodological foundations underpinning this study and provide the rationale for selecting a hermeneutic phenomenological approach to answer the research question: **How do Graduate Entry Nursing students in Aotearoa New Zealand experience the development of empathy in clinical practice?** To frame the research approach, I begin by discussing interrelated concepts of epistemology and ontology. Understanding what we consider as 'real' (ontology) directly shapes and influences how we come to know things, and how we interpret the world (epistemology) (Crotty, 1988; Pitard, 2017). Following this, I discuss the philosophical contributions of Martin Heidegger, Hans-Georg Gadamer, Max van Manen, and Patricia Benner. I examine their insights into Being, interpretation, human lived experience and discuss how their work directly informs the research design. I then move on to explain the rationale for using hermeneutic phenomenology. I explain why it is an appropriate and meaningful methodology to use to answer the research question.

3.2 Ontology

Ontology refers to the nature of being and existence, with particular focus on how individuals experience and interpret the world around them (Crotty, 1988). Ontological

inquiry within the research methodology of hermeneutic phenomenology is about seeking to uncover the conditions under which experiences become meaningful by acknowledging the influence of historical, linguistic, and interpretive structures (Nigar & Kostogriz, 2025). Crotty (1988) explains that ontology does not view reality as a fixed or objective set of entities, but rather, ontology is shaped through lived experience. Ontologically, in hermeneutic phenomenology, there is a dynamic relationship between an individual and the world, where being is understood as an ongoing process of interpretation (Heidegger, 1962). In this sense, ontology in hermeneutic phenomenology challenges traditional metaphysical views by asserting that reality is not static. Instead, what it does suggest is that reality is constructed through an interpretive process that is grounded in human experience (Laverty, 2003).

3.3 Epistemology

Epistemology is the study of knowledge and how knowledge is acquired (Sol & Heng, 2022). Epistemology refers to the process by which individuals come to understand and interpret the world, including their own world (Frechette et al., 2022). I understood this to mean that, rather than seeking objective, general truths, an epistemological stance would involve subjective, context-dependent understandings derived from lived experiences (Urcia, 2021). Gadamer (2004), whose work is discussed in section 3.8.2 further down in this chapter, explains that understanding is situated within historical, past and cultural contexts. He explains the importance of language, tradition, and preconceptions in shaping our knowledge of the world. Therefore, epistemology in hermeneutic phenomenology is the way in which knowledge emerges through practical engagement and interpretation of the world (Frechette et al., 2022).

3.4 Interpretivism Paradigm

Research paradigms define the ways in which researchers conduct their work. Research paradigms serve as frameworks that guide research through assumptions and principles (Keong Yong et al., 2023). For this study, the interpretive paradigm was selected. I understood interpretivism as a paradigm that assumes reality is mentally or and socially constructed (Alharahshah & Pius, 2020). Furthermore, it is a paradigm that assumes meaning is shaped by human perception, interpretation, culture, and social contexts (Alharahshah & Pius, 2020). This paradigm aligned well with the aim of this study,

understanding the lived experience of GEN students' development of empathy in clinical practice in Aotearoa New Zealand, as it explores subjective information derived from multiple realities as lived experiences. Interpretivism values subjectivity and seeks to understand the world through the perspectives of those who live it (Rehman & Alharthi, 2016). It is a paradigm that seeks to address narrative-rich data from participants lived experiences (Rehman & Alharthi, 2016). The interpretive paradigm is concerned with meaning-making, recognising that individuals interpret and construct their own realities in different ways, which is dependent on their background, culture and prior life experiences (Rehman & Alharthi, 2016).

As a research methodology, hermeneutic phenomenology sits within this paradigm as it seeks to understand the lived experiences of others (Grant & Giddings, 2002). In interpretivism, researchers are said to engage with the narrations of events that participants voice and then interpret these experiences. It is a making-sense-of and meaning-making process. Hermeneutic phenomenology is particularly important in nursing, where the work nurses do is relational, human-centred, and context-dependent (Hurley et al., 2022; NCNZ, 2025). Ontologically speaking, reality is relative and creates truths in our social and societal constructs, therefore engaging with the lived experience of participants and their "world" (Denzin & Lincoln, 2013). Through this lens, I aimed to understand how GEN students perceive, navigate, and make sense of empathy in their clinical environments**.**

3.5 Hermeneutic Phenomenology

Hermeneutic phenomenology, as influenced by Heidegger [1889-1976] and Gadamer [1900-2002], is both a philosophy and research methodology that focuses on the interpretation (hermeneutics) of lived experience (phenomenology). It is a research methodology that uses narratives and language to explore lifeworlds through the art of interpretation (Alsaigh et al., 2021; Neubauer et al., 2019). The aim of this study is to understand how GEN students experience the development of empathy in clinical practice by employing hermeneutic phenomenology as the research methodology. According to Neubauer et al. (2019), individuals cannot experience a phenomenon in isolation. One often refers to their background understanding of the phenomenon to help interpret it (Neubauer et al., 2019). As such, hermeneutic phenomenology is

particularly well-suited to this study, as it honours the complexity, depth, and context of human experience, allowing for a nuanced exploration of empathy as it unfolds and develops for students in clinical practice settings.

3.6 Phenomenology

Phenomenology is an umbrella term used to describe a philosophical approach and research methodologies that focus on how individuals perceive and make sense of their experiences (Alsaigh et al., 2021). Metaphorically, I see phenomenology as a large tree, with a central trunk, with branches that move out and away from the midline. Phenomenology was developed by Edmund Husserl [1859-1938], and it has since evolved into several different branches. In nursing and healthcare research, phenomenology is frequently used as a research methodology as it is grounded in the realities of experience and practice (Alsaigh et al., 2021). Phenomenology is a research approach that seeks to understand the essence of a phenomenon by asking: 'What is that experience like?' and 'How is it experienced?' (Dodgson 2023; Neubauer et al., 2019).

Phenomenology seeks to understand and then reveal what the consciousness sees and understands from an experience (Dodgson, 2023; Neubauer et al., 2019). It is by understanding how others see the world that a researcher can capture the essence of experience in phenomenology (Dodgson, 2023; Neubauer et al., 2019). Phenomenology is, therefore, understanding lived experience through understanding the lived experiences related to a phenomenon (Keong Yong et al., 2023). It is grounded in direct engagement with subjective experiences, such as emotional responses, bodily sensations, and interpersonal dynamics (Alsaigh et al., 2021). This highlights why phenomenology is commonly used in nursing, as it is engaged with understanding the emotional and relational aspects of individual experiences.

Phenomenology enables researchers to understand how individuals consciously experience phenomena, which can provide insights into the meaning-making processes (Keong Yong et al., 2023). By understanding *what* is experienced and *how* it is experienced, researchers who use phenomenology in their research can gain an understanding of the underlying structures of lived reality through interpretation. In this study, phenomenology allows for the interpretation of students' firsthand experiences

of empathy in clinical settings, providing insight into the richness of their evolving professional identities.

3.7 Hermeneutics

While phenomenology is concerned with the lifeworld of an experience and capturing the essence of that experience, hermeneutics is concerned with interpretation and meaning-making elements (Dodgson, 2023; Alsaigh et al., 2021). The word hermeneutics, etymologically, means "interpretive" (Harper, 2025). The word ‘hermeneutics’ comes from the Greek word *hermeneuein*, which means "to interpret... interpret into words, give utterance to," (Harper, 2025, n.p). The use of hermeneutics in research invites the researcher to engage with the narratives of participants, making sense of them, exploring the meanings behind these narratives, and assigning their experiences to understand how these meanings are shaped (Dodgson, 2023).

In hermeneutic phenomenology, the interpretation of information is both an art and a science (Chang, 2022), requiring the researcher to listen closely, reflect deeply, and remain open to evolving understanding. This idea resonated with me, as the blend of art and science is part of the reason I enjoy my work as a nurse and midwife. The process of interpretation is relational and reflective in nature (Chang, 2022). In this study, hermeneutics enabled me to engage with the narratives from the GEN student in a way that allowed for insights and meaning to emerge. Given the interpretive nature of hermeneutics, it is compatible with the values and practices of nursing, where understanding a patient's situation is integral to their care

3.8 Theoretical Background

To provide a solid foundation for this research, the following section explores the philosophical and theoretical contributions by four key figures whose work underpins hermeneutic phenomenology: Martin Heidegger, Hans-Georg Gadamer, Max van Manen and Patricia Benner. Each scholar brings a unique perspective to understanding the lived experience and contributes to the conceptual and methodological framework of this study.

3.8.1 Martin Heidegger

Martin Heidegger [1889-1976] was a German phenomenological philosopher who revolutionised the current understanding of human existence and its relation to the world (Stroh, 2015). Heidegger was a former student of Edmund Husserl [1859-1938] and is widely credited for transforming phenomenology from a purely descriptive methodology to an interpretive method of inquiry (Horrigan-Kelly et al., 2016). For Heidegger (1962), phenomenology was a way of revealing the ontological structures within human existence. I have interpreted this as Heidegger sought to uncover the meaning in everyday existence, with a specific focus on the experience of being and how individuals engage with their surroundings (Heidegger, 1962).

Heidegger introduced the concept of 'Dasein', or as it is translated from German into English, it can be understood and interpreted as 'being-in-the-world' (Ramsey, 2016). The concept of being-in-the-world explains the unique way individuals exist in the world (Stroh, 2015). Moreover, it can be interpreted as how individuals are in their worlds – their communities and areas in which they live (Stroh, 2015). This idea really emphasises the interconnectedness between all human beings and their environments in which they live (Stroh, 2015). Human experience is shaped by relationships with others, culture, language and historical background (Dodgson, 2023; Neubauer et al., 2019). By historical background, what is meant is the past. Past experiences that have occurred before in life.

Heidegger also made important distinctions between ontological (the nature of being) and ontic (the specific characteristics of beings) (Harman, 2007; Heidegger, 1962). To break this down, ontologically, Dasein refers to: the essence of being, while ontically, it refers to: the way individuals live and act in the world around them (Harman, 2007; Wrathall, 2025). Moreover, Ontic Dasein is Dasein as it shows itself in everyday experience (Wrathall, 2025). However, ontological Dasein is about the fundamental ways that a person is constituted (our temporal nature, being thrown into a world, our essential relatedness to being itself) (Wrathall, 2025). This is because we are mainly absorbed in the world of others (ontologically) rather than seeking to understand Dasein's existence within (ontic) (Harman, 2007). This distinction supports the idea that research should not only focus on observation/observed behaviours or actions, but

there is additionally a need to understand the deeper meanings behind those actions (Harman, 2007).

In this study, Heidegger's insights into hermeneutics of existence laid the groundwork for the fusion of phenomenology and interpretive understanding (Lammi, 1991). The emphasis Heidegger places on interpretation, temporality, and embeddedness offers a lens through which to view how GEN students experience the development of empathy in clinical practice.

3.8.2 Hans-Georg Gadamer

Hans-Georg Gadamer was a student of Heidegger. He is known for further developing hermeneutic philosophy as a research methodology by focusing on the nature of interpretation and understanding in human communication (Alsaigh et al., 2021). Both Heidegger and Gadamer argue that language is a means of beginning to understand being (Lammi, 1991), but Gadamer emphasised the role of language and tradition in shaping human understanding of the world. He argued that interpretation is an inherently dialogical process embedded within a historical context (Gadamer, 2004; Lammi, 1991).

Moreover, Gadamer advocated for a more nuanced understanding of knowledge (Gadamer, 2004). He suggested there is a *'Fusion of horizons.'* What he meant by this is that there is an interplay and merging between the one who interprets' information and the text or the phenomenon under study (Alsaigh et al., 2021; Laverty, 2003). This was important for me to understand, as in this study, I aimed to interpret the experience of GEN students, but I also needed to acknowledge that there would be an interplay between what the participants said and my interpretation of that dialogue. Just as the narratives that participants share with the researcher are their interpretation of an experience. Therefore, my goal as a researcher was to interpret and make-meaning from the experience in a way that shares the 'truths' of the participants understandings. In this way, I understand my role as an interpreter of an interpretation of an experience. Gadamer also stressed the importance of language in shaping understanding. Language is the medium through which meaning is revealed and shared (Regan, 2012). Gadamer explains that hermeneutic phenomenology is a methodology used "to explore the meaning of individual experiences in relation to understanding human interpretation"

(Regan, 2012, p.286). Influenced by Heidegger and Gadamer, hermeneutic phenomenology is both a philosophical perspective and a research methodology that focuses on understanding lived human experience through the art of interpreting communicated language (Alsaigh et al., 2021).

3.8.3 Max van Manen

Max van Manen's (1990) work bridges philosophy and practice, particularly within the disciplines of education, health and human science. van Manen describes phenomenology as the methodology for questioning the meaning of lived experience and sees the role of the researcher as engaging in a deep and reflective process of interpretation (van Manen, 2014). He asserts that phenomenology is not merely a descriptive exercise but an interpretive approach where the researcher engages with the meanings embedded in everyday experiences. Central to his methodology is the process of reflection on the meanings of lived experiences, emphasising how understanding emerges through the interaction between the researcher and the participants (van Manen, 2014). Van Manen's approach involves a careful, cyclical movement between the parts and the whole of the phenomenon under study, often referred to as the "hermeneutic circle" (van Manen, 1990). The hermeneutic circle refers to a process of moving between parts and the whole of a text to refine interpreting and understanding (van Manen, 2014).

What I interpreted van Manen to be saying here, is that analysis of information is a dynamic process that involves consistently revisiting insights in light of new understandings (van Manen, 2017). The movement between parts and the whole text meant that I needed to be adaptable in my approach to understanding the experience of the students. This is why van Manen call this a cycle, because it involves circling back to what was previously read and understood to make new meaning from (van Manen, 2017).

Hermeneutic phenomenology stresses the importance of the researcher reflecting on their own assumptions, as these influence their interpretation of the participants stories and therefore can interfere with meaning-making. Acknowledging these biases is participants responsibility to ensure the interpretation's authenticity and stay true to the participants lived experiences (Gadamer, 2004). My pre-understandings

are discussed in the next chapter in section 4.8. van Manen's contributions have also encouraged me to view the research process as a collaborative, dynamic relationship between researcher and participants, where interpretation is shared between us. In this sense, my research follows van Manen's belief that phenomenology is a human science that is not simply concerned with discovering objective truths but with creating a richer, more authentic understanding of human experience (van Manen, 2014). Another key contribution is van Manen's emphasis on the existential dimensions of experience, including lived time (temporality), lived space (spatiality), lived body (corporeality), and living things (materiality) (van Manen, 2014). These dimensions shape how one engages with the participants' narratives and how I will interpret them.

3.8.4 Patricia Benner

Patricia Benner is a scholar who has contributed to nursing theory and qualitative inquiry. Benner contributed to the application of phenomenology in nursing education and in clinical nursing contexts (Gill, 2014). Benner is best known for her model on nurse skill development, "Novice to Expert" (Benner, 1984). Novice to expert presents the developmental trajectory of nursing expertise. Benner explains through her model that nurses move through four distinct stages before they become an "expert". The developmental trajectory starts with novice, moves to advanced beginner, then competent, proficient, and ends with expert (Benner, 1984). These developmental stages show how a nurse's clinical competence evolves over time. Benner (1984) argues that a nurse's expertise develops through experience, reflection, and an intuitive understanding of situations.

Benner argues that nurses do not simply learn through the application of theory, but rather through engagement with real-life clinical situations and reflection on those experiences (Benner, 1984). Nurses acquire expertise through direct practice and reflection on their experiences with patients and in clinical settings (Benner, 1984). Her work highlights the role of experiential learning and reflective practice in the professional development of nurses (Benner, 1984). As nurses progress through the stages, their understanding of the context becomes more nuanced, enabling them to respond to patient care needs with greater sophistication and flexibility. Similar to Benner, I aimed to understand the unique lived experiences of students in their clinical practice and their skill development, specifically their development of empathy.

Therefore, her work and her framework 'Novice to Expert' have been used to help understand and make-meaning from the GEN students experiences.

The contributions of Heidegger, Gadamer, van Manen, and Benner have provided me with a greater understanding of hermeneutic phenomenology and helped build a theoretical framework for this study. All have provided invaluable insights into the complexities of lived experience and the dynamic interplay between the concepts of self, world, interpreter and clinical experience.

3.9 Why a Hermeneutic Phenomenological Approach?

> "If we knew what we were doing, it would not be called research, would it?" - Albert Einstein (1879-1955).

I have quoted Albert Einstein in the opening line of this subsection, as it is a reminder that uncertainty is a given at the beginning of any research. At the beginning of this study, I found myself in uncertainty, unsure which research methodology I would use. Indeed, I was not even sure what was meant by the word 'methodology', which highlights my ineptitude in conducting my own research. The process was new, and many of the terms seemed foreign. I was interested in understanding student experiences of empathy and developing such skills in clinical practice, but I had yet to finalise the research question. I knew that I wanted to pursue qualitative rather than quantitative research as a qualitative approach involves interpreting, understanding, and making-meanings from individuals or groups ascribing to a social or human problem (Creswell, 2021). Qualitative research allows the unique and individual voices of participants to be heard – their subjective experiences and perceptions (Creswell, 2021), an element of nursing and midwifery that has always interested me. Through discussions with my supervisors, I was encouraged to read about phenomenology and hermeneutics as the guiding philosophical methods for this study.

As I delved into hermeneutic phenomenology, I began to appreciate its focus on interpreting the detailed descriptions of lived experiences in regard to a phenomenon (Neubauer et al., 2019). As mentioned in Chapter One, I enjoy the blended art and science of working as a health professional. I was pleased to read that hermeneutic phenomenology and interpretation of lived experiences are also blended art and science. The art and science of interpretation would be central to my role as a

researcher. Therefore, aligning with the research aim to gain an understanding of the development of empathy in GEN students within clinical practice, hermeneutic phenomenology emerged as a fitting approach.

Taking a hermeneutic phenomenological approach aligns with my research goals, as it enables me to explore the experience and essence of empathy development among student nurses in clinical practice. Phenomenology provides a framework for me to address "how" empathy is developed, and hermeneutics enables me to interpret these experiences to uncover insights through meaning-making (Neubauer et al., 2019). The lived experiences of GEN students are central to the research question, as it asks *how* they *experience* empathy development. Therefore, using hermeneutic phenomenology to interpret language makes sense (Alsaigh et al., 2021). The decision to use this research methodology comes from the aim of interviewing participants, listening to their narratives, and deriving meaning from their experiences. However, it was important for me to recognise that the experiences shared by participants reflect their own interpretations, shaped by their own consciousness and past experiences. Saunders et al. (2012), as cited in Keong et al. (2023), note that in this methodology, the researcher contributes by subjectively interpreting the participants' narratives to make meaning from. As the researcher, I was mindful to act with care and interpret the shared experiences to derive meaning from the narratives and answer the research question, while remaining true to the participants' perspectives.

A hermeneutic phenomenological approach was selected as it offers a humanistic and context-sensitive framework through which to explore the development of empathy in student nurses. This research methodology allows me, as the researcher, to gain a meaningful understanding of how GEN students make sense of empathy in clinical environments, and how those experiences inform their growth and development of empathy.

3.10 Summary

In summary, this chapter has provided the philosophical and methodological foundation for the study, justifying and providing the rationale for the use of a hermeneutic phenomenological approach to explore the lived experiences of GEN students and their development of empathy in clinical practice. Grounded in the interpretive paradigm, the

hermeneutic phenomenological approach to this study recognises that reality is shaped through human experience, context and meaning-making. Drawing on the works of Heidegger, Gadamer, van Manen, and Benner, this chapter outlines how hermeneutic phenomenology offers a deeply reflective and interpretive lens for understanding the complexities of empathy development in clinical practice. Ontology and epistemology have been explored to understand the nature of being and the ways in which knowing influences the research.

In summary, hermeneutic phenomenology has emerged as a suitable methodology for this research as it captures the depth, richness and nuance of the GEN student's development of empathy in clinical practice. It is a research methodology that allows for the interpretation of experience while honouring the participants voices and the relational, reflective nature of nursing practice. The next chapter outlines the specific research methods used to conduct the study, including participant recruitment, interviews, and the process of interpreting participants' narratives.

Chapter 4 Research Methods

> "Vulnerability is the birthplace of love, belonging, joy, courage, and creativity. It is the source of hope, empathy, accountability and authenticity. If we want greater clarity in our purpose or deeper or more meaningful spiritual lives, vulnerability is the path." (Brown, 2012, p. 37).

4.1 Introduction

I chose to open this chapter with a quote from Dr Brené Brown on vulnerability because it captures a stance required for meaningful qualitative research. The research methods used in this study require a willingness to be open, authentic and courageous. These are all qualities that Dr Brené Brown associates with vulnerability. In advertising this study, and then engaging with student participants, I felt vulnerable. The entire research process has been a vulnerable experience. But moreover, being interviewed as part of a study is also a vulnerable experience. As a researcher, I needed to embrace uncertainty and build genuine, trusting relationships with participants. At the same time, the participants may have felt vulnerable while sharing their stories during the interview process. Therefore, I have placed the quote here as a reminder that vulnerability can be a source of strength in the research process, as it has the capacity to understand authentic insights.

In this chapter, I discuss how I have used the philosophical and methodological understanding of hermeneutic phenomenology from chapter three to approach the research methods. In this chapter, I outline how I came to advertise and recruit participants, how they were selected for participation, how I used interviews to collect their lived experience of empathy development from clinical practice, and what I did with their stories. This approach involved carefully analysing, sorting, reading and re-reading narratives to uncover emerging ideas using a method set out by van Manen (Beck, 2021). As the researcher, I interpreted the subjective realities of the GEN students in clinical practice to understand what that experience is like, to make sense of it, and to make meaning of their lived experiences (Regan, 2012). In this chapter, I also outline ethical considerations, cultural safety, and the responsible storage of participant information.

4.2 The Participants

The participants in this study were second-year nursing students enrolled in a Graduate Entry Nursing (GEN) programme in Aotearoa New Zealand. At the time of conducting this research, there were seven institutes across Aotearoa New Zealand that offered a GEN programme (NCNZ, 2024). However, only six tertiary institutes had second-year GEN students, as the seventh tertiary institute had only started its first semester of teaching the GEN programme when recruitment of participants began. I sought to recruit a total of six to ten participants, with an aim to recruit one or two students from each institute in Aotearoa New Zealand for representation across the range of nursing education providers. The number of participants was selected to protect me as the researcher, as this study was part of a 120-point master's research paper. If I had recruited more than ten students, the study would be too large for the requirements of this master's degree. Moreover, having fewer than six participants would make the research less meaningful as there would be fewer different lived experiences to analyse, and therefore, would lack depth (Sutton et al., 2015).

4.2.1 Inclusion and exclusion criteria:

To participate in this study, participants needed to fulfil the inclusion criteria:

Inclusion criteria:

- were 18 or older,
- were enrolled in a GEN Programme,
- had completed their first year of the GEN programme,
- were willing and able to participate in an online or a face-to-face interview,
- could speak English,
- had lived in Aotearoa New Zealand for at least six months.

Exclusion criteria:

Students who were excluded from the study if they were:

- students who expressed interest following the successful recruitment of participants,

- any student whom I or my supervisors had taught/had a supervisory relationship.

4.3 Recruitment of Participants

Following ethics approval by the AUTEC (see Appendix A), the Deputy Vice Chancellor of Research (DVC-R), or an appropriate representative at each tertiary institute offering the GEN programme, was approached to gain consent to advertise the study at their employed tertiary institute (See Appendix B for a copy of the letter sent to each tertiary institute). The DVC-R, or other appropriate person, acted as gatekeepers for participant recruitment (Dibley et al., 2020a). Their support in this research was essential for me to gain access to GEN students. Once access and approval were gained, the advertisement poster (see Appendix C) was displayed on each institute's online learning platform and physically on campus. The recruitment of participants began in March 2024. This process was staggered, with some institutes granting access much sooner than others. This was a process that took much longer than I had initially expected.

Prospective participants contacted me via text or email, as listed on the advertisement poster (Appendix C). After receiving an expression of interest (EOI), I sent participants the participant information sheet (PIS) (Appendix D), and a written consent form (Appendix E), both of which were approved by the Auckland University of Technology Ethics Committee (AUTEC). The PIS provided detailed, comprehensive, and relevant information that students needed to be aware of, including the study's purpose, the proposed method for collecting narratives for meaning-making, privacy protection, eligibility criteria, and participant rights. The PIS emphasised that participation was voluntary, and participants could withdraw at any time. They were also encouraged to keep a copy of the PIS for their records.

The signed consent form was returned by participants via email. This confirmed that they understood the study's details and consented to participate. This form was ethically required before a participant could be interviewed. Ethical values, such as promoting informed consent, must always guide how researchers share ideas and handle data (Saenz et al., 2024; Toulson Davisson Correia, 2023). To ensure the research data was handled ethically, I made sure to store the consent forms and all other digital records that contained participant information securely on AUT OneDrive, as this has a

two-factor identification required for access to be granted. This is to maintain confidentiality and protect participants' identities (Dibley et al., 2020a). The participants interview transcripts are also saved securely on AUT OneDrive and will remain in this secure location for seven years before being permanently deleted (Dibley et al., 2020a).

The PIS also included the “Participant Registration Details” form (Appendix G), which gathered information such as age, gender, ethnicity, clinical hours, and placements. When considering how I would reach the participants, I was mindful of time, cost, and accessibility to students. I wanted to facilitate a study design that would ensure participants could easily participate. To promote this, the “Participant Registration Details” form (Appendix G), allowed participants to indicate their preferred interview time, location, and mode (in-person or online via Microsoft Teams). In providing prospective participants with options, I upheld the principles of Tino rangatiratanga (self-determination), kōwhiringa (choice), and pātuitanga (partnership), as outlined in Te Tiriti o Waitangi (the Treaty of Waitangi) (NCNZ, n.d.-b). This approach promoted respectful decision-making, showed respect for participants' autonomy and fostered trust for meaningful engagement (Schmid et al., 2024). In this way, the participants had full control over their volunteer recruitment. The data collected from the Participant Registration Details form were also stored on AUT OneDrive for confidentiality, alongside other digital records, to be retained for six years before deletion (Dibley et al., 2020a).

Participants were recruited on a first-come, first-served basis. Those who expressed interest and met the eligibility criteria (see section 4.3) were invited to participate. While this research did not specifically target Māori participants, I aimed to include at least one Māori student from a GEN programme. Engaging with Māori is important in Aotearoa New Zealand, aligning with the core principles of Te Tiriti o Waitangi (the Treaty of Waitangi), which is New Zealand’s founding document between iwi and the Crown (NCNZ, n.d.-b). Te Tiriti o Waitangi (the Treaty of Waitangi) principles promote equity and empower Māori to define their own needs. By incorporating Māori perspectives on developing empathy in clinical practice, I would be safeguarding Māori knowledge, insights, and perspectives, and fostering collaboration between Māori and non-Māori (Wilson et al., 2021). Through understanding the experience of empathy

development in clinical settings for Māori, I would be in a position to advocate for change in nursing education and practice, through the voices of Māori.

4.4 Challenges in Recruiting Participants

4.4.1 Tertiary Institutes

Recruitment of participants began in March 2024 after agreements with tertiary institutes to advertise the study on online platforms and on campus were made. Six out of the seven tertiary institutes were eligible to be contacted, as the GEN programme had only just launched at another institute when recruitment commenced. As a result, recruitment was limited to six of the seven institutes initially planned. Consent from these six institutes was required and took longer than expected, with delayed responses and the need for fortnightly follow-ups, which set back the recruitment process and extended the research timeline. Other DVC-R declined consent to recruit GEN students from their institutes. Dibley et al. (2020a) note that the reasons behind gatekeeper decisions are often unclear, and in this case. Despite delays, other institutes eventually approved the study, but recruitment remained slow for several weeks. The time between students expressing interest and returning consent forms was longer than anticipated. Some students were on clinical placements and not attending campus, which reduced the number of students who saw the advertisements and further limited interest in the study. However, the delay gave me additional time to review existing literature on empathy, which enhanced my understanding of key concepts and prepared me better for participant interviews

4.4.2 Lack of Expression of Interest

When the study was first advertised in March 2024, students had not yet begun their second-year clinical placements. At that time, students were expected to remain engaged with their institutions, making advertising at tertiary institutes a suitable approach. However, the recruitment process took longer than planned, and by the time it was underway, many students had already started their clinical placements at external facilities. Recruitment via posters on online systems and campuses was unsuccessful from May to July 2024, with no student interest. After discussing the lack of responses with my supervisors, we concluded that the primary issue was that students were not on campus due to clinical placements and were missing the advertisements. As a result,

the posters proved ineffective, and students were likely too busy to participate if they had seen the study.

4.4.3 Amendments to Overcome Challenges

Due to recruitment challenges, I submitted two amendments to AUTEC to modify the research methods initially approved in December 2023. The first amendment, approved on August 1st (see Appendix H), which allowed me to use snowball sampling. Snowball sampling is a recruitment technique often used for hard-to-reach populations (Shaghaghi et al., 2011). Research by Valerio et al. (2016) found that snowball sampling significantly increases participant numbers in such populations, which was the case for second-year GEN students. This method involved contacting existing participants and asking if they knew any potential eligible participants (Shaghaghi et al., 2011). I aimed to increase participant recruitment through networking, while ensuring that participants were neither disadvantaged nor advantaged during this process. The amendment also addressed the participants' clinical placements, which limited their time at tertiary institutes. Therefore, I requested that the study be readvertised in October 2024, in consultation with the appropriate staff members at the institutes.

The second amendment, approved on October 10th (see Appendix I), allowed for advertising the study on social media, via Facebook and Instagram groups. Social media is widely used by students for communication and third-space learning, which occurs outside traditional learning settings (Giroux et al., 2022; Jaastad et al., 2022). Almutairi et al. (2022) note that social media enhances nursing students' engagement through interaction and communication. Given that research showed that students frequently use social media, it was a fitting platform for advertising the study (Mühlhoff & Willem, 2022). As social media is not bound to a physical location and allows the shareability of information, I aimed to reach a broader audience of students this way. Despite gaining approval from the AUTECs for this recruitment strategy, it was unnecessary, as the technique of snowball sampling and readvertising the study facilitated the recruitment of the required number of participants for this study.

4.5 Pre-understandings

As I discussed in Chapter One – Introduction, the act of being 'reflexive' in qualitative research involves the ability to examine one's own beliefs, assumptions, and judgments,

in order to consider how these might influence the research process (Jamieson et al., 2023). By engaging with reflexivity at each stage of the research process, particularly prior to interviewing the participants, I enhanced my understandings of these preconceived ideas, beliefs, and assumptions, that resulted in greater transparency of the research (Jamieson et al., 2023). The research supervisors interviewed me to explore my pre-understandings and how these had evolved.

Prior to the pre-understandings interview with the research supervisors, I had reviewed the questions. I wanted to be sure of the questions before they were asked of me. However, during the interview, I found it difficult to draw upon my prior thoughts and found the process of being interviewed more challenging than I had expected. I felt pressured to perform well, be well articulated in my responses, and provide the "right" answers, despite the goal of the interview being a way of reflecting and responding honestly. I sometimes struggled to answer the questions, needing time to reflect before answering. This experience taught me the importance of patience and silence when interviewing participants, allowing them time to process and respond thoughtfully, as my understanding of interviews prior to this experience was that elaborating on or sharing a lived experience would be easy to articulate, as it was simply just putting words to an already experienced situation. This interview was challenging but invaluable. It helped me understand the vulnerability and discomfort interviewees might feel, the challenges of self-reflection under pressure, and how my own experiences shaped my approach to the research, including the topic and methodology. This again links back to why I selected the opening quote for this chapter. I learnt that vulnerability in research is essential.

4.6 Interviews

Seven GEN students who had completed their first year of study in a GEN programme in Aotearoa New Zealand volunteered to participate in this study. All participants come from three different tertiary institutes, all from the North Island of Aotearoa New Zealand. All participants identified as female and identified as either European, Asian or Māori. While not statistically significant, having Māori representation in this study is meaningful, as understanding the lived experience of Māori GEN students may help in shaping recommendations for future nursing practice and education. This is particularly

important, as Wilson et al. (2021) note in their research, Māori ways of knowing have been silenced, neglected, and ignored in the past. Therefore, it was important to me that Māori had a voice in this research due to historical under-representation and my acknowledgement of Māori as tāngata whenua (people of the land) (Hudson et al., 2010).

Participants were interviewed to stay aligned with a phenomenological approach of gathering information to understand *how* GEN students experience the phenomenon of developing empathy (Sutton & Austin, 2015). Ontologically, reality is relative (Denzin & Lincoln, 2013), meaning multiple socially constructed realities and truths exist. The most logical way to understand the realities of developing empathy for GEN students in clinical practice was through asking the students, How is that experience and What is it like? Therefore, I interviewed participants. Interviews promoted a personal and tailored response to each question that was unique, individual and was entirely reflective of *their experience*.

Participants were able to self-determine where the interview would take place, choosing between two options: kanohi ki te kanohi (face-to-face) at their tertiary institute or online via Microsoft Teams. Engward et al. (2022) note that in-person interviews tend to be longer and more comprehensive, but they also assert that online interviews do not limit rapport-building between the researcher and participant. As such, Microsoft Teams was an option if kanohi ki te kanohi was unachievable or the student preferred this option. Kanohi ki te kanohi interviews were preferred because they offered connection, understanding, and relatability. However, the participants did not know that this was my preference. Participants indicated their preferred interview option on the Participant Registration sheet (see Appendix G) before sending it back to me. Allowing the participants to determine when and where the interview took place, it not only upheld the principles of Tino rangatiratanga (self-determination), kōwhiringa (choice), and pātuitanga (partnership) but also increased the likelihood of the interview taking place. Moreover, evidence suggests that the location of an interview can change the power dynamic between the interviewee and the interviewer (Quinney et al., 2018). As phenomenology is about sharing lived experience through kōrero (conversation) and language, I was conscious to not create an environment where kōrero (conversation) flowed. Elwood & Martin, 2000 explain that having the researcher choose the location

of the interview can cause power imbalances, which can consequently cause participants to feel uncomfortable, which can affect the quality of the information shared with me. As such, it was important to me that the participants self-determined the location so they would feel more comfortable and safer during the interview process (Elwood & Martin, 2000).

Interviews began in April 2024 and were completed in November 2024. All seven participants chose to interview via Microsoft Teams and selected the date and time of the interview. Students were instructed to have a device that was sufficiently charged to last a 60-minute video call, with a working microphone and a functioning camera, on the day of the interview to facilitate effective communication. Students were instructed to have a reliable internet connection to prevent disruption during the interview. Additionally, participants were asked to find a private and confidential space with minimal distractions while the interview was conducted. I asked this of participants to promote engagement and to minimise discomfort in them telling me their stories. Each participant was interviewed once, with interviews taking less than 50 minutes.

Rapport, as described by Spradley (1979) and cited by Schmid, Garrels, and Skåland (2024), refers to the relationship between people that facilitates the free flow of information, which is essential for effective interviews. To promote rapport during the interview process, I prioritised cultural safety and whakawhānaungatanga (relationship-building) at the start of each interview rather than diving straight in with questions about their experiences in clinical practice. Whakawhānaungatanga emphasises the importance of relationships with whānau (extended family) and healthcare providers (Wilson et al., 2022). To honour this, I invited participants to have a member of their whānau present during the interview if they wished. All participants declined this offer.

I spent time at the start of interviews introducing myself, explaining how I came to this research, the research aim and the participant's role, in the hope of establishing a sense of trust and understanding, and minimising discomfort and uncertainty (Hudson et al., 2010). It was at this time, that I too reminded participants that they could stop at any point during the interview and only answer questions they felt comfortable with, adhering to the ethical considerations of this study. Moreover, I remained mindful to

hold a warm and open manner, smiling and using the 'phenomenological nod' (Dibley et al., 2020b) to encourage a supportive environment. The 'phenomenological nod,' a concept attributed to van Manen, is a technique that can be used during interviews to show agreement with the participant's words and to foster a validating environment (Dibley et al., 2020b). Interviews began with a welcome and an optional karakia. I asked participants if they were comfortable and ready to start, ensuring a calm, participant-directed space. Additionally, participants were offered an opening and closing karakia (prayer or chant) during the interview, contributing to a culturally safe environment (Moorfield, n.d.-a). Before each interview began, I obtained oral consent for voluntary participation in the study, and consent to be audio recorded, in line with the AUT oral/verbal consent form (see Appendix F). All consent forms and digital records were securely stored on AUT OneDrive, accessible only to me through two-factor identification.

It is suggested that interviews in phenomenological research should have a few guiding questions, to encourage openness in the conversation (Smythe et al., 2008). This approach ensures that the interview remains on track while still allowing for flexibility in the discussion (Smythe et al., 2008). According to Alsaigh et al. (2021), Gadamer emphasised that the essence of the questions asked during interviews opens possibilities for a deeper understanding of a phenomenon. For this reason, I used a semi-structured interview technique, encouraging participants to respond to open-ended questions through kōrero (speech and storytelling). These semi-structured interview questions can be found under Appendix L. This approach aligns with the principles of hermeneutic phenomenology, which seeks to understand human experiences through language and communication, interpreting the meaning of lived experiences (Keenan, 2017; Nigar, 2020). My role as the researcher was to promote a space that felt safe and comfortable for participants to share their experiences and engage in meaningful dialogue (Sutton & Austin, 2015). I asked open-ended questions to promote conversational dialogue and regularly checked in with participants to ensure they felt comfortable proceeding. Participants consented to being audio-recorded at the start of the interview. Interviews were recorded on Microsoft Teams, and the content was manually transcribed. I reviewed and checked the recording against the transcriptions three times to promote accuracy and ensure reliability for the findings section of this

study. After the interview, I documented reflective notes in a diary to try and make sense of my understanding of the participants' experiences following each interview, ensuring confidentiality at all times.

4.7 Reflection Point

I had anticipated that the first interview would be one of the hardest to conduct, but I was determined to use it as a learning experience if nothing else. I was not sure if the semi-structure questions I had written would be easily answered by the participant, or if they would find these questions quite challenging to answer. After the interview, I allocated 30 minutes of uninterrupted time to reflect on what went well, what didn't, and how I could improve. I wrote notes and used mind maps to assist in the process of self-development. As mentioned above, I continued to reflect after each interview.

My aim as the researcher was to create an online space where participants could speak freely, without fear of giving the "wrong" answer. I would pause after the participant finished speaking to ensure they had completed their thought, being careful not to interpret or speak over them. Probing questions, such as "Can you tell me more about..." or "What was that experience like for you?" were used to invite participants to share their experiences. I learned that participants were either comfortable sharing their stories from the start or reserved, hesitant, or physically uncomfortable. The more interviews I conducted, the more comfortable I became in them. Reflecting back on the initial interviews, I was not as relaxed or relational with the participants as I had hoped. The interviews were an ongoing process of learning, reflecting and refining (Slade & Sergent, 2023). With each interview, I continuously improved.

4.8 Meaning-Making

Philosophical insights from Heidegger, Gadamer, van Manen, and Benner helped to shape how I made meaning from the participants' stories. It was important for me to remember what Gadamer emphasised about an individual's past deeply influencing their interpretation of an experience (Taylor, 2019). Therefore, the data that I had collected were the experiences of GEN students based on their past subjective experiences and interpretations of those experiences.

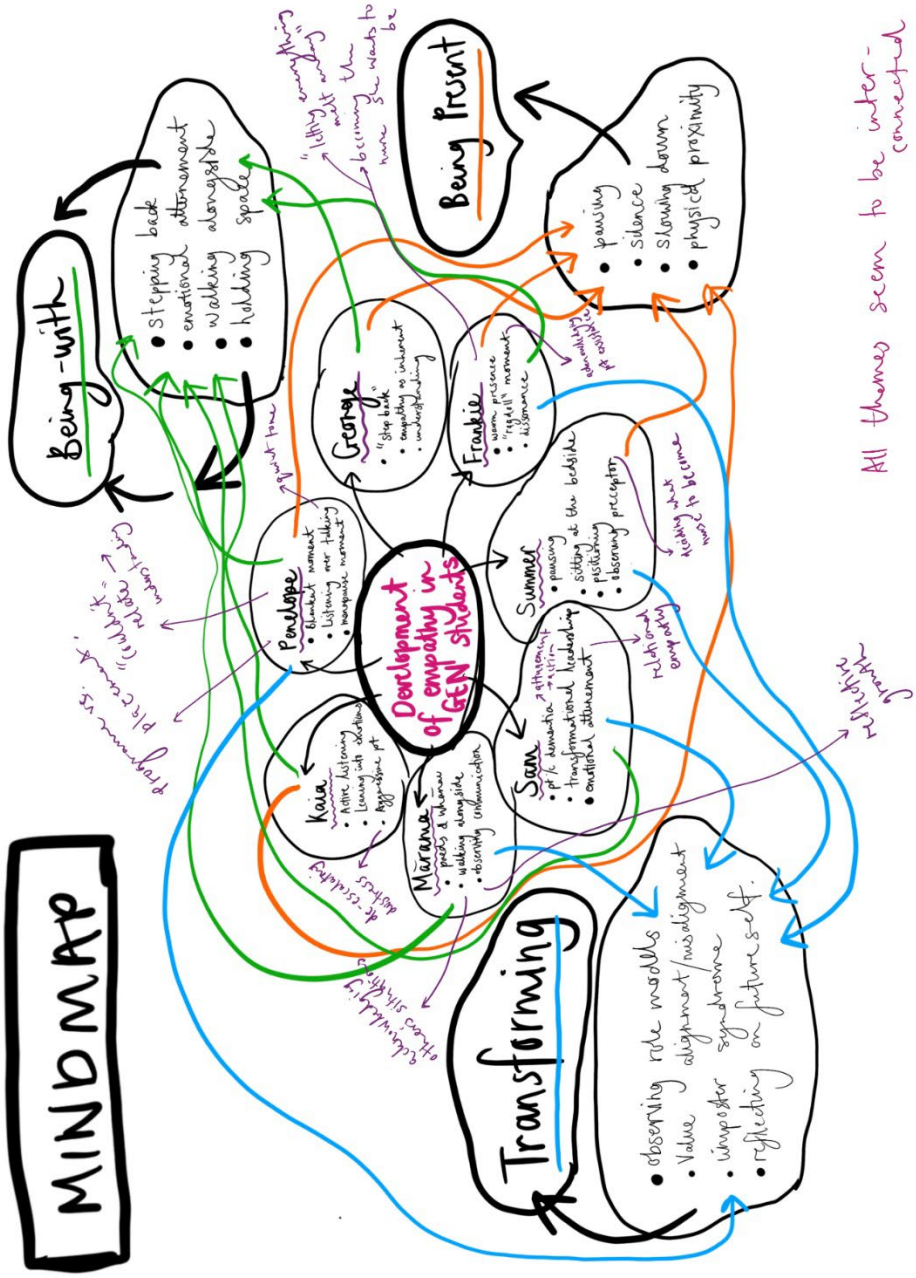
Hermeneutic phenomenology is known for its cyclical approach to data analysis (Dibley et al., 2020b). van Manen (2014) spoke about this cyclical process as being the 'hermeneutic cycle'. What this means is that, unlike other approaches used to analyse data, hermeneutic phenomenology involves moving from interpreting individual parts of narratives to understanding the whole experience, and then moving back to individual parts, etc. (Dibley et al., 2020b). Dibley et al. (2020b) explain that this cyclical method of meaning-making, where the researcher moves through a process of consistently refining their interpretation of narratives by reflecting, re-reading, and re-reading sentences and phrases to come to interpret and understand the whole experience, takes time for immersion. I adopted van Manen's six-step analysis approach to meaning-making and the interpretation of participant narratives. van Manen's six-step analysis includes 1) turning to the lived experience, 2) collecting lived experiences, 3) theme analysis, 4) phenomenological writing, 5) maintaining a relationship with the phenomenon, and 6) creating coherence by balancing themes (Bastami et al., 2022; van Manen, 1990).

By this stage in the study, I was up to step three: theme analysis. Before reading the transcribed interviews, I reflected upon van Manen's philosophy that research is an act of care. Van Manen views caring and an act of care in research as an ethical relationship response, where the researcher has a moral obligation to protect participants and others involved (van Manen, 1990). I, too, aimed to approach this study with care and thus reflected on the work of van Manen, using it to guide my research approach. Maintaining confidentiality and privacy posed potential challenges for me, as participants often mentioned the name of the clinical placement setting where an experience occurred. Information such as clinical placement locations, clients, or names of faculty members were mentioned throughout interviews and sprinkled throughout the interview transcriptions. To maintain privacy and confidentiality and act with care, I edited any identifying details from the interview transcripts, including modifying names and personal information of clients or clinical settings (Dibley et al., 2020a). As the researcher, I could not guarantee anonymity; however, what I could do was ensure confidentiality by renaming participants with pseudonyms and by using careful redaction. After checking and rechecking the accuracy and confidentiality of the interview transcripts and editing and adding pseudonyms, I engaged in the meaning-making process of theme analysis.

Theme analysis began with an immersive process of reading through the interview transcripts to gain insight into the participants lived experiences, while remaining open and curious (Dibley et al., 2020b). I began identifying initial themes and patterns between participants lived experiences by reading and re-reading the interview transcripts. I created a mind map as a visual way of making sense of all the stories shared with me during the interviews. Mind mapping helped me break the data into smaller units, focusing on sentences, phrases, and significant experiences to identify underlying meanings and themes (Dibley et al., 2020b). By immersing myself into the stories and mind mapping, I began to cluster together related themes and sub-themes and considered how these interrelated within the broader experience of developing empathy in clinical practice across Aotearoa. This process was cyclical in that I would always come back to reflection, examining the interpretations in light of the research question to ensure that I was answering the question at hand and going back to the interview transcripts until I was satisfied with the themes that had emerged from the data. Figure 7, as seen below, is an example of my mind mapping.

Figure 7

Mind Map Example



4.9 Ethics

Ethics form the cornerstone of all research, especially in healthcare and in Aotearoa New Zealand, where Te Tiriti o Waitangi (the Treaty of Waitangi) must be upheld (Auckland University of Technology, n.d.-a). This study upheld the ethical values of accountability, respect, responsibility, human rights and welfare, integrity, and fairness, as these form the foundation for guiding research conduct (Guillemin & Gillam, 2004). In this study, ethical and cultural considerations were embedded throughout the research design,

data collection, analysis and dissemination process, with prioritisation given to informed consent, confidentiality, participant well-being, and adherence to Te Tiriti o Waitangi (the Treaty of Waitangi) (Health Research Council of New Zealand, 2010a).

Ethics approval was sought from the AUTEC in December 2023. This application was approved on December 14th, 2023 (see Appendix A), with two "Non-Standard Conditions of Approval" addressed without further approval (see Appendix H–I).

4.9.1 Te Tiriti o Waitangi and Te Ao Māori

All research conducted in Aotearoa, New Zealand, must respect and consider Māori as tāngata whenua (people of the land) and uphold Te Tiriti o Waitangi (the Treaty of Waitangi) (Hudson et al., 2010). Prior to commencing the research, I reviewed the ethical guidelines and regulations of AUTEC and *Te Ara Tika: Guidelines for Māori Research Ethics: A Framework for Researchers and Ethics Committee Members* (Hudson et al., 2010), which outlines four key principles that have shaped my research design:

- Whakapapa – relationships and connections,
- Tika – integrity and appropriateness,
- Manaakitanga – Care, hospitality, and respect,
- Mana – justice and equity (Hudson et al., 2010).

Additional Māori ethics concepts guided this study, including: *Tino rangatiratanga* (self-determination), *pātuitanga* (partnership), *active protection, equity*, and *options* as Māori have the right to choose their social and cultural pathways, acknowledging Māori as tāngata whenua with mana whenua (Māori rights over the land and its occupation of Aotearoa) (Moorfield, n.d.-b; NCNZ, n.d.-c). These principles guided my understanding of the researcher's roles, rights, and responsibilities while contributing to evidence and outcomes for Aotearoa New Zealand (Hudson et al., 2010).

The New Zealand Nursing Council *Code of Conduct* (NCNZ, n.d.-b) and the New Zealand Nurses Organisation *Code of Ethics, 2019,* (n.d.), integrate ethical values from te Ao Māori (Hunter & Cook, 2020), acknowledging Māori cultural values and principles. Te Ao Māori refers to the Māori worldview, which encompasses Māori customs, beliefs, and values, such as concepts of whānau (family), tāngata whenua (people of the land), manaakitanga (care and hospitality), and tino rangatiratanga (self-determination) (Hunter & Cook, 2020). These guidelines promote practices that align with Māori cultural

perspectives and promote cultural safety and uphold Māori voices in research (Hudson et al., n.d; NCNZ, 2019; NZNO, n.d.-c). The *Te Ara Tika* Guidelines for Māori research ethics emphasise cultural safety and are aligned with Māori principles of collective well-being and establishing meaningful pātuitanga (partnership) with Māori communities (NCNZ, n.d.-c).

As a registered health professional, educator, and student researcher, I committed to upholding these ethical principles throughout the study, which promoted a research approach that was informed by mindful mahi (work). I aimed to create a supportive environment that was culturally safe for all participants, regardless of their cultural or ethnic backgrounds (Wilson et al., 2022; NZNO, 2011). Through this process, I developed an understanding of the key ethical values derived from te Ao Māori and how these principles inform and guide research and aimed to uphold them in this study (NZNO, 2011).

4.10 Bias and Rigour

Bias in academic research refers to any systematic distortion or error that influences the results or conclusions of a study in a way that is not due to the natural occurrence of events or randomness (Pannucci & Wilkins, 2010). A bias in academic research often leads to inaccurate or unfair conclusions as the researcher has selectively chosen to confirm their pre-existing beliefs or assumptions (Pannucci & Wilkins, 2010). Therefore, to produce academic research that results in conclusions that are accurately interpreted, bias of any variety should be avoided (Pannucci & Wilkins, 2010). However, Pannucci and Wilkins (2010) argue that bias is almost always present in published studies, so it is up to the reader to consider how bias might have influenced the study's conclusions. Moreover, a 2012 study suggests that this bias is increasing (Joober et al., 2012). I aimed to prevent bias and attempted to eliminate it from my research. To reduce this, I participated in pre-understanding interviews, kept journals, and considered what the participants were telling me, rather than what I wanted them to tell me. My aim was to remain neutral.

Rigour in academic research refers to strict adherence to research methodologies and procedures that ensure the research findings are of a high quality, reliable, credible, trustworthy, and valid (Mays & Pope, 2000). Rigorous research is systematic, thorough,

and objective, and it minimises the chances of errors, biases, and inconsistencies. In qualitative research, rigour is often discussed in terms of trustworthiness, which includes credibility, dependability, confirmability and transferability (Nowell et al., 2017). To ensure credibility, this study adopted a research design well-suited to exploring the lived experience of GEN students during clinical practice, hermeneutic phenomenology. The data for this study was collected through in-depth interviews, which allowed the participants to reflect openly on their experiences. Having open questions allowed participants to bring rich, reflective responses to each question. To promote dependability and transparency, the research process was carefully documented. This process involved maintaining detailed notes of decisions made during the interview and analysis processes. Reflexivity was maintained through regular journal and supervision meetings, which helped to bracket preconceptions and minimise confirmation bias. The pre-understanding interview helped me to reflect on and bring to light these pre-conceived ideas. Confirmability was supported by peer debriefing and supervision feedback, ensuring that the findings were grounded in the interview findings rather than my own assumptions. Transferability was added by providing rich descriptions of participant contextual information, such as the educational stage, clinical placement environments, and nature of interactions with CE and RN preceptors.

4.11 Summary

This chapter outlined the suitable methods used to conduct the study. The chapter has outlined the participant recruitment and interview processes, detailing the careful steps taken to ethically collect and protect participant details and their stories. This chapter has also addressed the measures I took to maintain confidentiality for participants, health consumers, and clinical settings where students' had clinical placements. This chapter contained the steps in van Manen's six-step analysis that I have followed while conducting this research. Furthermore, this chapter demonstrated how ethical and cultural considerations, particularly in relation to Te Tiriti o Waitangi (the Treaty of Waitangi), and te Ao Māori, were central to the research process.

In the next chapter, I present the key findings of this study and explore how these address the central research question. I draw on the participants narratives from the interviews and incorporate direct quotations from the transcribed data to support my

interpretation of their lived experiences in relation to empathy development in clinical practice.

Chapter 5 Findings: Being-Present, Being-With, and Transforming

> "Self-compassion is key because when we're able to be gentle with ourselves amid shame, we're more likely to reach out, connect, and experience empathy." (Brown, 2012, p. 68).

5.1 Introduction

This chapter presents the findings that answer the research question: **How do Graduate Entry Nursing (GEN) students in Aotearoa New Zealand experience the development of empathy in clinical practice?** This chapter presents the findings in themes, using the participants' own words: being-present, being-with, and transforming. Example quotes from interviews illustrate just how empathy is developed in clinical practice for GEN students. Pseudonyms have been used in place of participants' real names to protect their confidentiality. This findings chapter reflects the experiences of GEN students by drawing upon Heidegger's understanding of *Dasein* (being-in-the-world) and van Manen's exploration of lived experience to understand how the experience of empathy development emerges in nursing practice. van Manen (2014) notes that hermeneutic phenomenology is not a fusion of two methods but a relationship of inquiry that embraces the interpretation of human understanding and the richness of lived experience. In this chapter, I have used hyphenated terms such as being-with, lived-time, and being-with-others to reflect key concepts in phenomenological language and function symbolically as a conceptual bridge, emphasising the fluid relationship between concepts.

I have chosen the introductory quote by researcher, Dr Brené Brown, to introduce this chapter as it shows how important it is for nurses to be not only empathetic towards others, but also for themselves in their work caring for others.

5.2 Being-Present

The theme of being-present is about the small, subtle gestures. The theme emerged as a central thread woven through the participants' narratives. It reflects a shift from being in an environment of *doing* to one of *being* in clinical encounters. For participants, presence did not mean simply being physically alongside a patient or completing tasks. Presence was experienced as an attentiveness to the emotional and existential

dimensions of care. Through their reflections, it became clear that *being-present* involved intentional and often intuitive, subtle gestures, and an openness to pause and connect. This theme explores how participants came to understand presence and full engagement with others as a meaningful form of care that was relational, situated, and often expressed through quiet acts of listening, waiting, and active engagement without distraction.

Summer shared the story of working with a nurse preceptor during a clinical placement. During this experience, Summer explained that she felt supported and began to understand the notion of time and being-present:

> *My preceptor was someone who, sort of, spent a bit more time and would pause. They were available for patients to speak up or have a moment to think if they had anything else to say. And then that was kind of apparent when someone just took that extra couple of seconds to stand there, sit, or get on the same level as somebody else.* [Summer]

Summer's narrative reveals empathy emerging as temporally situated attunement, where the preceptor's pausing creates what Heidegger might call a 'clearing' (Lichtung in German) for an authentic encounter (Heidegger, 1962). She observed empathy as a form of being-there-in-the-moment, in which the preceptor remained attuned to the patient rather than moving immediately on to the next task.

This kind of attunement reflects van Manen's (2014) view that creating pauses or allowing space is integral to meaningful learning and interaction in practice. Healthcare environments often impose time constraints that limit such presence. However, Summer sees that her preceptor paused and remained present with the patient, which created space for potential reflection or disclosure by letting meaning develop in the silence and letting-be. The clinical preceptor was offering guidance simply by being-present, by pausing. The pause acted as a form of invitation to the patient. It was a non-verbal gesture that signalled openness and attentiveness. This moment of shared presence was a natural response to the patient's needs. Instead of rushing to the next task, the preceptor embodied presence.

Similarly, Frankie shared a moment from a clinical placement in a dialysis unit. Frankie told me that the population group accessing this dialysis unit were mostly Pacific

peoples and that she recognised that perhaps this meant that they would be unable to return home to their island homes, even for a holiday, due to a lack of dialysis units in the Pacific. Frankie shared that she worked with an RN who also recognised this and made it his mission to provide patients with his full engagement, attention, and spent time getting to know them. Frankie explained:

> *He would ask questions. Not just about their medical situation, but he would ask about their families and their personal life because that's obviously so important, and that's being affected by dialysis, like a lot of these whaiora [person seeking health]; they come from Pacific island countries, and they do not have dialysis machines at home. So, how can they go home? They cannot*. [Frankie]

Frankie also shared:

> *The RN who I was allocated to work with, he would make conversation with them. That kōrero or that conversation was like his warmness and the way he talked, his smile, he was very relaxed, and I'm not. I am quite a tense person. I think because I get very stressed and I have got so much to do but sometimes it is OK, just be with this person and just everything else as to melt away for a second and really focus on them. And he was so good at that.* [Frankie]

A recurring theme in both of Frankie's narratives is the impact of attention and active engagement in developing and demonstrating empathy. Frankie explained that the RN went beyond routine clinical questioning, asking patients about their families and personal lives, which was viewed as empathetic because it acknowledged the broader context of the patient's life, particularly for whaiora (person seeking health), from Pacific Island nations. Frankie explained that the questions signalled a genuine interest in the person, not just their condition, which fostered a sense of connection and understanding that transcended clinical care. For these patients, needing to receive medical care in Aotearoa New Zealand could be frightening, lonely, and culturally challenging for the whaiora (person seeking health). Frankie witnessed the RN leaning into these feelings and emotions that those he was caring for might be feeling at that time and tried to provide them with a safe, comforting presence. Frankie also described how an RNs relaxed, warm manner stood in contrast to her own tendency to feel tense and rushed. In observing him, she realised the importance of slowing down, letting everything else “melt away,” and giving her presence to the person in front of her. She realised that her presence with others may affect the way in which empathetic care is

seen and felt by others. Frankie is talking about the contextual nature of empathy, which is about understanding things around oneself, not simply through thinking, but also through feeling (Hedger et al., 2018). Frankie is considering the bodily postures and facial expressions that the RN makes when conversing with others, which provided her with valuable information for how to position herself to be present with others (Hedger et al., 2018). The slowing down that Frankie discussed suggests how the temporal nature of empathy —being slower and more present in the moment —can be a tool used to create a space for silence, helping the unspoken reveal itself to both patient and student.

Whereas George shared her experience of empathy as something implicit and inherent to her being. She describes empathy as embodied, something that has evolved within her over time rather than being a skill consciously acquired during clinical placement. Rather than actively deciding to "be empathetic", George experiences empathy as part of her natural way of relating to others. She explained:

> *I guess you don't really think about empathy throughout everyday life. I guess it's kind of something you think about and is part of being human, but it's not something you think about specifically. OK, you know, I do not think, 'now I will be empathetic.'* [George]

George's reflection points to empathy as an intuitive, pre-reflective process. In her clinical practice, she does not intentionally "activate" empathy but instead responds in a way that emerges naturally from her embodied experience. This aligns with van Manen's (2014) view of empathy not as a purely cognitive or deliberate act, but as an embodied, lived way of being-with-others. Physical presence is said to be the inviolable core of therapeutic practice, which is fundamental in nursing practice (Arribas-Ayllon, 2023). But George also experienced empathy as something far deeper and more intuitive, rather than a conscious act. George's capacity to be present with patients arises from an internalised, evolving sense of empathy shaped by past experiences and carried into the present. In this way, her presence and patient care are relational and responsive. She is grounded in the moment. As van Manen (2014) suggests, care often emerges from this pre-reflective space, where empathy is felt and enacted through being, rather than a deliberate intention.

The notion of being-present was also reflected in Penelope's narrative, where she observes how being-there with a patient can convey empathy and care. Penelope

describes an interaction where her nurse preceptor allowed the patient to speak freely, without interruption or overcompensating with comforting words. Instead, the RN demonstrated empathy through tone, attentive listening, and a calm presence:

> *… I saw that my nurse, my nurse preceptor she was letting her [the patient] do a lot of the talking, but also, you know, there's no, like it was not like talking very loudly to comfort them or saying things like, "oh, honey", you know, it's very down to earth the way they comforted them. And you could tell that, you know, they actually empathise quite a lot… I sometimes think it is just better to listen than add in your little bit… I found that true empathy sort of comes through in that form.* [Penelope]

In this account, Penelope interprets empathy as emerging not from what is said but from the quality of presence. The nurse's down-to-earth demeanour, tone, and quiet attentiveness created a space where the patient had the space to talk. Penelope identified that "sometimes it is just better to listen." I have interpreted this as acting with restraint and attunement, which contrasts with action or explanation. Her reflection, therefore, emphasises how presence can be embodied through listening and silence, allowing the patient's experience to unfold without interruption. It is slow. Penelope's engagement with the moment reflects the act of being-present, and the ongoing development of her capacity to be-with-others in a meaningful and empathetic way. Silence is not the absence of meaning; it is also a mode of expression. Some participants have learnt from the silence by not rushing or leaping into interpretation or fixing things, by being aware of non-verbal cues. This comes with taking the time to be mindfully present in the moment and not feeling rushed by the pressures of other tasks.

By being open to the patient and taking the time to be there, Kaia too was able to understand that being-present in a moment can help others as offering time and presence allows time for staff to understand the patients whole experience, not simply just their experience with the clinical task at hand. Kaia shared a story from when she was on a clinical placement at a GP clinic. A patient, already experiencing pain and frustrated, reacted aggressively during a procedure. The student remained calm, offered the patient options for a different or more senior nurse, and then gently asked them about what had happened and how they felt. Kaia explained that remaining present to listen and be passive, rather than focusing solely on the clinical procedure, changed how the patient reacted and interacted.

> *Maybe they are hungry. Maybe they are thirsty, maybe their situation is that they did not have a good sleep because of that CPAP machine… the nurse had to put the gauge in, and this was important to get that iron infusion done, as that led to all of the comorbidities for the patient. However, definitely my support of just being an active listener and being passive also helped.* [Kaia]

This narrative reflects Kaia's ability to consider the patient's potential unmet needs (e.g., hunger, sleep deprivation, discomfort from a CPAP machine) as contributing factors to their current behaviour, rather than responding solely to the clinical task. Kaia looks beyond clinical tasks to consider the patient's physical and emotional state. She shows care and interest in them by actively engaging with them and asking questions about their experiences. The shifts from task-oriented care to reflective inquiry. Kaia shows a growing ability to attune to the patient's lived experience. Furthermore, Kaia's reference to "being an active listener and being passive" reveals that she is recognising empathetic presence. She recognises the importance of quiet attentiveness. This suggests a nuanced awareness of how simply being alongside a patient in an attentive and non-intrusive way can offer meaningful support. It is recognising the patient as a person and responding with care.

Being-present is not a function of showing up physically, demonstrating technical competence, or procedural knowledge. Being-present is an evolving practice that is grounded in empathy. It is an embodied act. Of small, subtle acts. It is seen through relational understanding, active engagement with others, intentional pauses, quiet listening, and in silence. Being-present can create space for patients to feel seen, heard, and valued. Presence, in this sense, is not an add-on to empathy but a core expression of it. These moments of shared presence also signify important learning experiences for the students themselves, as they understand that genuine empathy often resides not in what is done or said, but in the slowing down, in the silences and in the ways in which we position ourselves to show "we are here for you, we are here to listen".

5.3 Being-With

Being-present explored how students learnt to dwell fully in clinical moments, moving beyond task completion, toward attuned engagement with the human dimension of care. Being-present speaks about the engagement in the moment with another person and about being attentive and actively engaged without getting distracted, whereas this

next theme, being-with, reveals the relational foundation of empathetic practice, where students develop capacity to share emotional space and walk alongside patients. I found this theme perhaps the most challenging to interpret and make meaning from. I had three ideas and understandings: Being-with, attuning and caring. Heidegger's concept of Dasein refers to human existence and our way of being-in-the-world (Heidegger, 1962). Dasein is about being-with-others and being-there, shaped by relationships, actions, and an awareness of our shared existence (Heidegger, 1962). This was similar to what I was noticing in being-with. However, caring emerged as GEN students saw caring for others something they are learning to embody. Heidegger (1962) described Being-with (Mitsein) as the inherent connection between humans and care as one's attention to one's presence in the world (Tomkins & Simpson, 2015). Befindlichkeit, or attunement, is how people are tuned into the world around them and how we relate to our being and the beings around us (Coate, 2023; Tomkins & Simpson, 2015). These concepts spoke to the quality of presence at the bedside and the relational connection based on shared moods, communication, and authentic being-with that students and RNs brought to their interactions with others. GEN students spoke of a need to be-with their patients and whānau through caring, connecting, and creating a space where patients could share their unique situations to be-with others.

Initially, this section was separated into two themes: (1) being-near, and (2) attunement and caring. Upon separating these themes, I realised I could not keep them apart. The students spoke of being near to patients and attuning to their needs to connect with them and their moods, feelings, and emotions, creating a space for authentic being-with. The students' narratives demonstrated that being-near, attuning, and caring were intertwined concepts, so I have maintained this connection. The theme of being-with demonstrates that relational process, attuning and caring are interwoven. Without attunement or caring, the concept of being-with others ceases to exist. The theme of being-with captures the subtle yet powerful way that being near and tuning into others is expressed in clinical practice. I have interpreted this theme to be expressed through emotional availability, attentiveness, connection, and relational closeness to others. Being-with involves attuning to the needs of another, beyond physical needs. Being-with involves offering space to attune into their inner world, without intrusion, and responding in ways that foster comfort, trust, and connection with another through

a shared relationship between our Being (Sein) and the Being of others (Heidegger, 1962). It is based on our shared moods, emotions and feelings.

In the following section, stories from GEN students illustrate how nearness and being-with offer patients a sense of being held, heard, and accompanied in their experiences and explore how students come to recognise, connect with, and develop relational understanding, empathy, self-awareness, attuning, and caring as they develop throughout clinical practice. This section begins with a story from Penelope.

Penelope shared an experience an acute hospital placement. She felt that the hospital felt more like a 'clinical conveyor belt' than a space where people were cared for and treated with empathy or the respect she believed that they deserved. Penelope explained that the element of *care* was missing. Heidegger (1962) speaks of care (Sorge) as how humans are connected to and involved with the world around them. Penelope explained that it would not have taken much to demonstrate care in the situation, and in her eyes, she noticed that it is the small gestures that really count. She shared:

> *I've seen doctors, nurses and HCA's [health care assistants] just forgetting about the patient being uncovered, and I can because I'm a student. I'm obviously sort of a step back sometimes, so I just noticed them [the patient] reaching for the blanket, covering up, and it is such a small thing, but you really do need to.* [Penelope]

Penelope's reflection shows how being "a step back" to understand and to develop is not a physical step, but a metaphorical one. As a student, she is present in the clinical setting but not yet responsible for the full continuum of care. This position allows Penelope to observe subtle and often overlooked movements, like a patient, covering themselves for dignity or warmth or another meaning. Heidegger (1962) talks about authentic distance in care, where 'distance' is not the physical separation between individuals, but a philosophical stance that enables empathetic connection as it promotes authenticity and freedom. Distance in care allows others to be who they are, without others imposing on or jumping ahead of another and anticipating their potential, which can take away their care (Heidegger, 1962). Her attentiveness to these small acts shows an emerging empathy shaped by her attunement to the patient's world. Even though she is on the periphery of professional care, she remains engaged in the situation, noticing what others may have missed. And indeed, what they do miss.

Despite the metaphorical step back, she remains *with* the patient's and their world by noticing their emotional needs.

Penelope demonstrates Verstehen or understanding of the patient's experience during clinical practice (Tomkins & Simpson, 2015). Penelope explained that she could see the patient reaching for the blanket and recognised a shared feeling with the patient, because she was in a place where she could really see the patient. Heidegger (1962) would argue that this is a fundamental aspect of human existence; to be open to the world and others in a way that acknowledges their lived realities, which are often unspoken but deeply felt. Penelope may not be close to the patient physically, but she is near in a sense. She is connecting and understanding their world, which allowed her to lean in and be-with them and speak the unspoken words of "I see you. I am here for you".

Like Penelope, George also mentions the phrase 'step back' in one of her stories. During her mental health clinical placement, George initially found it challenging to understand how she could care effectively for the health consumers she was working with. Over time, she realised that her role was less about performing hands-on nursing tasks and more about being-with the clients as they navigated their difficult experiences. She described this as "taking a step back", a deliberate interpretive process that allowed her to engage with the client as a whole being, rather than reacting solely to their behaviours. George shared:

> *I have just been on my mental health placement… but when you take a step back and look at them, you see a lot of traumatic backgrounds and yeah. There are things like you feel, what you are doing is not so much nursing, but OK, asking them, "Well, how can we actually help you?" rather than reacting to the behaviour they are presenting with, and asking yourself why are they acting like that and how can we help?* [George]

George explained that caring for clients with poor mental health and traumatic backgrounds played a significant role in shaping how she understood how to care for them. George began to understand that someone's situation and background informs how they see the world. This aligns with Gadamer's (2004) argument that interpretation is an inherently dialogical process embedded within a historical context. George recognised that clients may not always have the words to express their distress, but their

behaviours reveal important truths about their lived reality. George speaks of relational experiences with clients and shifts her focus to an experience of being-in-the-world with them.

When George explained that she can “take a step back” and look at the client as a whole, she can care for the entire client. When she says this, she does not mean that she physically steps back from the patient, but that she can metaphorically step away from a task-oriented mindset and into one that allows for empathetic care of the whole client. This act of stepping back reflects George’s shift from a task-focused approach toward a relational and person-centred mode of care that emphasises understanding the client’s being-in-the-world. Stepping back helped George to understand the trauma the patient experienced without having experienced it herself. George shared that she could understand the person's world from their perspective and be-with-them, at a metaphorical distance, to ask questions and gain a deeper understanding of their whole experience. This distance emphasises being-with and being-nearby. In this way, she is engaged, not as a distant observer, but as a fellow human navigating the complexity of lived experience with another. This perspective aligns with Heidegger’s (1962) concept of "being-with", where those caring for another are not distant or detached but are actively engaged with the patient as a fellow human being.

For George, empathy development in this context involves shifting toward understanding the meaning behind the client's actions and experiences, rather than simply labelling those actions as problematic. George told me that open interpretation and acknowledging that patients may not always have the words to explain their distress or experience, but their behaviour conveys something important about their lived reality. Connecting with that creates a sense of togetherness in care, which helps to shape empathy. This example circles back to their theme of being-present, as there are cross-connections between all concepts.

Just as George noticed the element of care beyond task-orientated care, Kaia witnesses the same. Kaia recounts when a patient and their whānau entered a General Practitioner (GP) practice. The whānau had expressed frustration at not being able to see a doctor. Kaia shared that the whānau became aggressive due to the stress related to the situation. Kaia witnessed the nurse she was working with lean into the feelings

underlying the patient's experience. Kaia explained that this moment demonstrated being-with the whānau and sharing a space for the whānau and the RN to connect through the shared moods and frustrations. Kaia explained:

> *There was an incident when one of the clients in our GP practice came in, and they were in a very aggressive mood because they could not see a doctor, but they felt that the child was too distressed. So, to calm the situation down, it was not that the nurse approached them in the same way; it was just to settle them down, just listen to them, just acknowledge, and that already de-escalated the situation a lot.* [Kaia]

Kaia explained how this challenging situation could have escalated if the nurse she was working with had not taken the time to 'just listen to them' and create a sense of harmony to foster empathetic understanding. Kaia's reflection contains elements of the theme being-present but sits well in the theme of being-with, as the nurse demonstrated to her that the act of being-with someone evolves wanting to engage in understanding of their moods, feelings and emotions. By listening to the patient and acknowledging their situation, Kaia and the RN could lean into being-with the other. The concept of being-in-the-world places emphasis on our active engagement with the world and others, where we are immersed in relationships (Heidegger, 1962). Kaia noticed that the RN decided to lean in and approach the whānau (family) with calmness and a desire to connect with them and listen with the intention of understanding their world. Kaia noticed that the nurse skilfully recognised the emotional state of the client and engaged with them authentically. Kaia saw that listening and acknowledging the client's concerns allowed for a moment of connection and calmness. Heidegger (1962) talked about this intention of leaping into help fix something for someone, which can unintentionally disempower them from their own possibilities and undermine their dignity and autonomy (Dewar et al., 2023). Without an immediate solution to the problem, the RNs nonverbal communication of patience and calmness helped de-escalate the situation and created harmony by listening and offering reassurance. Kaia shared how the nurse demonstrated care and empathy by being-with, attuning to their experience by listening and holding space for shared understanding and not attempting to fix things.

Mārama shared an experience that also involved a distressed family member of a child who was not well. Mārama's story is from her time spent in a paediatric area.

Márama shared how the idea of nearness with-others emerged in this clinical context, where direct communication with the patient is limited, but communicating with the whānau is essential. In Márama's reflection, she recognised how empathy must extend to parents and caregivers:

> *It is a paeds [paediatric] department. So that is the first time that I have worked solely with children and families. I guess that is probably why my empathy has maybe changed a little bit is that you work with a family a lot rather than that the patient themselves because they do not. Umm, you know, you can't necessarily communicate the way that you would with an adult. I watched the nurses have two patients and be really empathetic and understanding towards whether it is the mother or the father, not necessarily relating it to their own life and their own family, whether they were mothers or not, but, I suppose, understanding their frustrations and concerns with delays and diagnostic testing that wasn't happening.* [Márama]

Márama mentioned how this clinical placement was the first time that she had worked with tamariki (children) (Moorfield, n.d.-c) and their whānau (family). Márama suggested that her level of empathy and understanding of this has evolved due to this experience, as she began to recognise the importance of engaging with the whole whānau rather than just the individual or, in this instance, the child. Márama was attuned and absorbed (Verfallen) to the situation (Tomkins & Simpson, 2015). Márama points out that it can be challenging to communicate with Tamariki (children), which differs from communicating with adults, and how this can complicate the expression of empathy. Márama explained that the parents of the tamariki (children) were frustrated due to diagnostic delays. The recognition of these feelings and emotions highlights the importance of not just addressing the medical concern but also acknowledging and understanding the emotional distress faced in a clinical setting and being able to support this distress.

Empathetic care is not limited to nurse–patient interactions; it also arises among team members within the clinical environment. Sam, another GEN student participant, reflected on a clinical placement experience that revealed a new dimension of empathy, where she witnessed empathy embodied in a member of the nursing leadership team. She recalls a nurse manager who demonstrated what Sam describes as transformational leadership and empathetic care. Like Márama and Penelope, she emphasised that sometimes care involves simply being-with-others, listening, attuning to others'

emotions and needs, and responding in a way that alleviates pressure and fosters connection. Before sharing this story, Sam paused and took time to return to the memory and reflect on its significance. Sam shared:

> *I was not feeling like she is a manager. She was a friend as well but, good leadership skills. So, I felt like it was a transformational leadership skill. The teamwork and communication were good. There was no communication gap, and she was even doing the tasks. During lunchtime, she [the nurse unit manager] was talking about some of the things [tasks], and we were not feeling like it was work pressure. She was giving. It is distributing the task to each team member. I felt like this was an example of empathy.* [Sam]

Sam's reflection reveals a nuanced understanding of empathy as being-with others as she reflects on the transformational leadership of the nurse unit managers ability to be emotionally available and attuned to the lived experiences of the nursing staff (Rahman, 2017). “Transformational leadership is a style of leadership where the leaders are believed to have a high level of emotional intelligence” (Rahman, 2017, p. 51). The nurse manager, as Sam explained, was not distant or detached from their clinically working team. Rather, the nurse unit manager was embedded within it. As they were in it, experiencing it, they were able to sense the emotional tone of the workplace and colleagues and distribute tasks in a way that supported others rather than burdening them.

Sam observed the leader’s quiet presence, attentiveness, and ability to recognise the emotional and practical needs of staff. Sam shared how empathy emerged through relational experiences, through being-with-others, sharing space, and responding to the needs of others. Tomkins and Simpson (2015) acknowledge that true leadership is something that we feel as much as know. Sam described them to be *with* their team. They were participating in the shared rhythm of the workday because they understood the feelings of their team members. Sam saw that empathy can be embodied in many forms, including leadership. Leaders and managers can sometimes be perceived as distant or out of sight from their teams, but Sam’s story illustrates how transformational leaders can be empathetic by listening and attending to their staff's needs through the simple act of being-with.

The experience of being-with often involves a quiet, relational closeness that does not seek to resolve or explain, but to be-with the other in their experience. Márama shared another experience from clinical practice where she speaks of "acknowledging someone else's situation" and "walking alongside" someone. She speaks of sharing the feelings and moods of others, which can shape empathy. Márama shared:

> *I guess like acknowledging someone else's situation that they might be in and like being understanding of that, not necessarily like relating it to my own situation, but yeah, being able to like to acknowledge and walk alongside them and support them in whatever way possible with whatever they are going through*. [Márama]

Márama captures the essence of being-with as walking alongside another. In this way, Márama began to recognise that genuine empathy can involve understanding another's feelings without needing to draw on parallels from her own life. In this way, Márama was setting professional boundaries and allowing for more genuine support by maintaining a professional distance. Brown (2021) states that boundaries are a prerequisite for empathy and compassion, and without these boundaries, we cannot connect with others. Márama uses the phrase 'walk alongside them", which I have interpreted as meaning she understands the emotions of another's inner world, but she maintains distance and does not try to take away that emotion. Rather, she stays close and with them – maintaining professional distance.

This is a form of emotional connection with another that is grounded in empathy yet does not centre around the self. In this way, being-with can be interpreted as the relational and affective closeness that enables care to emerge in subtle, yet meaningful ways (Arribas-Ayllon, 2023), and in a willingness to 'walk alongside them'. Márama articulates a sensitivity to the experience of others, recognising that to be empathetic does not mean mirroring or comparing. For empathy, in this sense, Márama did need to have experienced all the things a patient had to be empathetic towards them. She was able to walk alongside them in shared humanity. She was not trying to compare or fix. She was just *there* for the other person. It is being attuned to others' experiences that helps GENs develop authentic and empathetic care. From van Manen's (1990) perspective, this captures the theme of lived relationality, where empathy is expressed through intentional, thoughtful attentiveness to the other's world. Márama emphasises

the importance of offering support through attentiveness and providing space for meaningful connection.

Frankie shared a story where she noticed the patient's humility and lived experience, which also resonated with van Manen's (1990) concept of lived relationality. Frankie initially took on an observer's role, watching the staff she was working with as they attended to a patient, but then moved into the care of being-with the patient as she stood with the patient and walked with them in their world.

> *She would have felt like a rag doll, and I was just witnessing this thing. Obviously, it was like one of my first days, and I wasn't involved in the actual manoeuvring of her. And so, I was just watching this from an outside point of view, and I kind of just ended up actually kind of standing near her head and kind of bending down, looking at her. And I was like she looks so frightened, you know. I was like, 'it is OK. It is OK', and I was just kind of, like, petting her hand. I was trying to explain like OK, next they are going to do this and this is what's happening, you know, and I and I didn't really. I couldn't give the best explanation of what was going on because I was also like, What's going on? But I just felt like she needed someone to acknowledge her existence as a human and not just as things like tasks that need to be done on someone, you know what I mean. So that was kind of a bit of a wake-up call with like the importance of empathy when someone's at their worst or at their most scared.* [Frankie]

Frankie shared this experience of what she had earlier described to me as a "traumatic experience". Frankie recounted how, very early on in a clinical placement, she had a profoundly negative experience involving a patient. She described the patient as potentially feeling like a "rag doll" as they were tossed around without care by other staff members. The use of the wording "rag doll" speaks to the reduction of the patient as a mere thing that is present-at-hand, rather than a person with human needs and feelings. In Heidegger's philosophy, care is fundamental to human existence (1962). Heidegger's care is not about providing physical care; it is about being concerned for the well-being of others and being connected to others. Treating another human like 'a rag doll' does not demonstrate care or empathy because it reduces the patient to an object rather than a human being with feelings and emotions that require connection.

Frankie recognised this reduction and dehumanisation of the patient, which was evident when she says, 'I was just witnessing this thing'. The use of the word 'thing' says to me that Frankie recognised the humanity and personhood in this patient, yet

witnessing the patient being manipulated and handled like an object, and therefore, Frankie did not have another way of describing what she had seen, as it did not involve an element of care or consideration to the person and their experience. Frankie initially felt hopeless in this experience but then found her footing and rose to the occasion. In this experience, she was able to recognise not only her own embodiment but also the embodied experiences of her patient, which meant she was able to be with the patient and communicate with them, which made them feel seen and less objectified. She was with them and connecting to their underlying feelings related to their lived experience. My own understanding of empathy as relational (as described in my pre-understandings) finds resonance here, yet Frankie's story pushes beyond my initial interpretation of empathy towards something more embodied and immediate.

Penelope shared the story of working in a General Practitioner's (GP) clinic where the team was short-staffed. Due to this, she supported her nurse preceptor by triaging patients as they arrived to be seen. She recounted feeling unable to relate to one patient's presenting complaint, as she had never personally experienced it. The patient had recently moved to Aotearoa New Zealand and was adjusting to a different lifestyle while also going through menopause. Penelope reflects:

> *I was the triage nurse. Well, student nurse, but short staffing… I felt I could not relate. But umm, I could definitely understand, you know, a changing body, especially during a time when you've already started a different lifestyle change. So much stress.* [Penelope]

In this moment, Penelope is not separate from the world of the patient; she was situated within it and open to it. When I first read Penelope's experience, I understood it mainly as her feeling unsure of herself and her ability to relate to the patient at that time. However, after reading and understanding the narrative of other students and then returning to her story, my interpretation had shifted. I began to see that what Penelope had described was not just about self-doubt, but it reflected how empathy can emerge when we encounter difference. In this moment, Penelope was moving towards the patient's world, finding common ground through shared emotions. This reflects Gadamer's (2004) idea of a "fusion of horizons," where understanding is not about sameness but about opening ourselves to the perspective of the other.

Penelope stated, “I felt I couldn’t relate” when she first met the patient, which conveys a sense of distance or disconnection from the patient’s experience. Despite the unfamiliarity with the specific life stage, Penelope's response reflected her perceived limitation in understanding the patient’s lived experience. Yet, she shifts from this literal sense of “not relating” to a more nuanced, empathetic position where she can connect with the emotions of the experience and move closer to being-with the patient in this experience. Penelope recognised aspects of the patient’s situation, such as stress, physical change, and life transitions, as part of a broader human experience and moved closer to the patient’s world, even without having shared the same circumstances in her life. Penelope was self-aware of her own limitations, by stating “I could not relate”, but her interpretation of the lived experience of the other is an essential component of developing empathetic care in clinical practice. Penelope shared: “I could definitely understand, you know, a changing body, especially during a time when you've already started a different lifestyle change”, which speaks to both a maintained distance and an emerging closeness. Penelope does not claim to have an identical experience but connects through shared emotional ground. She is linking her experiences of stress and transition to the patient's feelings. In doing so, Penelope demonstrates a movement from disconnection and not being able to relate to a more authentic and relational understanding of the patient’s lived reality, which allowed her to be with the patient and, therefore, express empathy towards their situation.

Collectively, the stories of clinical placement from GEN students illustrate how empathy is seen through stepping back, being-near or close, and attuning to others in their vulnerability. The participants spoke of a willingness to hold space to connect with the emotional and existential realities of patients, whānau, and even colleagues. Being-with reflected the ability to walk alongside another in the moods and feelings of their experiences. In their reflections, the GEN student participants have shared a glimpse into the beginnings of a professional development that is human and responsive to the world of the other.

My interpretation of the students’ experiences changed as I moved back and forth through the student narratives. Frankie’s description of “petting her [the patient’s] hand”, I initially saw as Frankie leaning in to offer comfort. However, after considering other GEN students’ narratives, such as George’s account of “taking a step back,” in

mental health, I came to understand this gesture of Frankies as part of the broader theme of being-with. Throughout the theme of being-with, I noticed the emerging theme of development. But beyond development, I noticed the GEN student participants beginning to develop transformational empathy.

5.4 Transforming

The theme of transforming captures the gradual shifts GEN students experience during clinical practice. In clinical settings, students are expected to learn, grow, develop, and transition into confident nurses, encouraged to gain as much clinical knowledge and exposure to diverse experiences as possible. Many students find themselves faced with complex and emotionally charged situations where they reflect on the care they have witnessed during the course of their clinical placement. It is in these moments of reflection that students begin to experience transformation. While some may feel uncomfortable, these experiences can become important growth points that help transform GEN students. Through repeated engagement with patients, whānau, and clinical teams, students start to question their assumptions, reflect on their values, and develop a deeper sense of empathy. This section begins with a story from Summer.

Summer reflected on a moment of insightfulness. She observed how her RN preceptor engaged with patients, which revealed a growing sensitivity to how positioning in clinical encounters communicates availability, an openness and shapes the potential for relational connection. In this reflection, Summer describes how observing her preceptor helped her recognise the importance of being-present and positioning oneself in nurse-patient interactions. Summer explained:

> *Another thing I noticed from my preceptors is to pause and either sit on the chair there or be up close to somebody, rather than standing at the end of the bed. You know, if they're standing right in the curtain, they're obviously sort of half turned around already, and you're unlikely to get the patient to open up to you and you know, be available like that. And so, I think it's been quite insightful to see a variety of different approaches and reflect on that and either think, oh, I'm going to do that or, you know, maybe not, that's not how I would approach that. And I'll make sure I don't do that when it's my turn.* [Summer]

In this story, Summer is thinking about the nurse that she will be in the future by reflecting on the examples of care she has seen during her clinical placement

experiences. She uses her clinical placement experience to question whether she will adopt or avoid certain methods in her future practice as an RN. Her narrative highlights an awareness of how physical positioning and spatial presence influence interpersonal dynamics in clinical settings. Her awareness speaks directly to van Manen's (1990) concept of lived space, which refers to how space is experienced emotionally and relationally. This concept speaks to how space is experienced rather than occupied (van Manen, 1990). In this narrative, Summer speaks of choosing to "sit on the chair" or be "up close to somebody" as not a practical decision but a relational gesture to foster openness, trust, and the possibility of deeper engagement and empathy with the patient. In contrast, Summer describes standing at the end of the bed or behind the curtain as creating an implicit physical and emotional distance. Her observation is that this positioning makes patients less likely to "open up" or "be available." Summer highlights in this example how space can serve as a means of creating a relational space or a barrier to empathetic connection when inhabited in certain ways. This is a similar positioning to the earlier themes of being-present and being-with, where students developed the capacity to share emotional space and moved beyond completing tasks, toward attuned engagement with another person.

Benner (1984) states that an expert nurse possesses experience and can utilise that to their advantage, viewing situations as a whole, while the novice nurse must rely on conscious, deliberate actions. Novice nurses can begin to think more contextually by drawing on lived experiences to inform their judgment and actions (Benner, 1984). Summer's reflection on developing empathy is evident in her shift from passive observation to embodied, values-based decision-making. By determining what to replicate and what to avoid, she integrates empathy into her own behaviour, tailoring her approach to the specific situations and people she will encounter in her future clinical practice, informed by her past nursing experiences and applied to her current clinical practice.

Mārama also speaks to a growing awareness and shared an experience of observing a nurse during a clinical placement. Mārama shared that this was a challenging situation, which helped her to develop an empathetic way of practising. Mārama's narrative explained how clinical practice settings are about transforming and becoming

attuned to the emotional needs of others and learning how to apply concepts like empathy. Mārama explained:

> *I think I learned a lot from observing… you don't want to feel like you're intruding as a student and going into exams or going into difficult conversations that the clinicians are having with the patients or their family, but it's also like really, good learning for me to see how they communicate and how they get their message across, how they answer questions and things… it's great to observe, but I'm also very conscious sometimes that it can make… the families feel uncomfortable.* [Mārama]

Mārama expressed her desire to learn through observation and participation in challenging situations, aiming to understand how to act and respond effectively in her future practice. Again, thinking about the future nurse she will become. For Mārama, the act of observing is a reflective, relational, and deeply situated experience that is vital to her and her development in clinical practice. Observation in this context requires slowness, which refers to van Manen's (1990) concept of lived time, where individuals move through time based on 24-hour segments. However, time is subjective, and meaning unfolds gradually as the dimensions of the past, present, and future are interconnected (van Manen, 1990). The stillness of observation allowed for a deeper level of noticing subtle interactions, where Mārama became aware of tone, posture, presence, and the use of silence, through what she labelled as ‘observing’. This space of slow, relational observation contributed to her transformation as a nurse, where she gained a sense of awareness and emotional responsiveness to patients, which is foundational in developing empathy. Many students find themselves deeply engaged in reflective learning by being-present, being in the patient's world, and being near, all of which involve the concept of time (van Manen, 2014). Observation is vital for creating space for students to dwell, notice, respond, and reflect on practice as they begin to integrate their personal identity with a professional one.

One powerful example of transformation is illustrated in Sam’s interaction with a patient living with dementia. In this encounter, Sam moved beyond the patient's immediate behaviour and attuned to their deeper emotional state. This experience illustrates how being-attuned to a patient’s emotional state prompted reflection, action, and growth for Sam. In this situation, Sam encountered a patient who was visibly distressed upon answering the call bell. What unfolded in this experience for Sam

became an important moment of recognising the human need for connection and comfort. Sam recounted:

> *I went to see the patient and noticed that he was very agitated... I said, 'If you want to go home, that's fine... I called the other nurse and said, 'This patient is very agitated, and I think he needs medication'... We were aware of the feelings of the patient, knowing that he has dementia and misses his family... After that, we contacted the family because he was missing them and wanted to know if they could meet him.* [Sam]

Sam describes her experience by beginning with a simple observation: "the patient was very agitated." I see this as something deeper. Something unfolding. A more empathetic engagement as Sam responds with calm reassurance and advocates for the patient's needs by seeking assistance from another nurse. Her actions mirror an emerging confidence in emotional connection and emotional intelligence, as she needed to interpret the patient's distress. Sam looks beyond a behavioural issue and sees someone who is expressing an emotional need. Sam recognised the underlying feelings of the patient and their inner world, which shows a shift from reacting to the symptoms of the patient's behaviours to connecting to the person's lived experience, and seeking to connect to what's happening inside for them.

This moment reflects the concept of lived relationality, which speaks of relationality or lived human relations as "the lived relation we maintain with others in the interpersonal space that we share with them" (van Manen, 1990, p. 104). As van Manen (1990) describes, this is a way of being-with others that is responsive, sensitive, and open to their affective reality. Sam became attuned to the affective world of the patient, recognising that instead of looking at the behaviour, she looked at what might be causing the behaviour, and began to understand the underlying feelings and emotions that triggered the behaviour. By recognising the patient's longing for whānau (family) connection and acting upon it, Sam demonstrates a growing capacity to read situations holistically and respond to the patients' needs in a way that affirms their dignity and humanity. Her response is not merely clinical; it is relational and ethical, grounded in a desire to alleviate suffering through connection (Ringwald & Wright, 2021).

Akin to Sam, Penelope transformed her development of empathy during clinical placement experiences. However, Penelope believes that the learning and discussions in classroom-based situations did not aid her in developing empathy. For her, it was working with others during clinical practice that helped her to foster empathy and translate this concept into her own practice. Penelope reflected on her time in the degree by saying:

> *I wouldn't say the programme itself helped me. Because they had their open discussions, especially around cultural safety and things like that, where empathy is very much big topic, but I don't feel like it necessarily helped me build it more… It's very much, you know, being in placement and things like that 'cause I think I have I had some, a little bit of empathy before I came into the programme.* [Penelope]

Penelope shared that although the GEN programme addressed important topics such as cultural safety, she gained more from real-life patient care. She points to a gap between talking about empathy and experiencing it within the practical context of nursing. Without opportunities to embody empathy through direct patient care and reflective practice, the programme's content felt removed from the lived reality that truly nurtures empathetic development. Penelope also described the impact of having supportive clinical educators during the clinical placement experience:

> *It's really important for your lecturer to be very approachable and for that clinical lecturer [clinical educator] to actually talk about their own values so that it inspires you and motivates you to figure out your own cool values… I feel like seeing both good and bad, being able to share that with someone who will appreciate you and what you've seen.* [Penelope]

Penelope's reflection shows that she recognised improving her practice as a transformational moment when she had time with the clinical educator (CE). She saw these moments as opportunities for growth. Benner (1984) talks about the notion of moving from novice to advanced beginner and how this process involves both time and reflection. Benner (1984) also suggests that novices rely on rules and move toward making more intuitive, values-based decisions. van Manen's (1990) concept of lived relationality also emphasises how meaningful relationships can help to foster the development of empathetic understanding. In this situation, the educator's openness creates a safe space for Penelope to process both positive and challenging clinical

encounters, which enabled reflective practice, and Penelope was able to transform by integrating personal values into her professional identity as an RN.

Like Penelope, Frankie also reflected on the importance of shared values in clinical practice, but her experience highlights the tension that can arise when those values are not mirrored by others in the clinical environment.

> *As a student nurse, I kind of have that impostor syndrome. It's like, "OK, I'm not as experienced as these nurses. I'm just shadowing a preceptor. I'm like, very much in the background". ... sometimes I feel like a puppet". Sometimes I am just observing and doing as I'm told, and I don't really have that opportunity to be autonomous in my care or how I want to care. Like we just have to look at RN's and be like, OK, they're doing this like that. Therefore, I need to do it this way because that's, they're more experienced than me and this is how it needs to be done… but the difficult part is when you see nursing [practice] that don't align with our values or patients get dismissed and their needs aren't being taken seriously or being properly listened to.* [Frankie]

Akin to Summer, Frankie is thinking about the nurse she wants to be and moving from a position of doing what other nurses do to 'fit in', to a position where she is aware of this practice of following others and is seeking to be in a position where she can be autonomous and practice nursing in a way that allows her to uphold her values. Frankie wants to be acting empathetically in her practice, and spend the time being with-others and listening to them, to gain an understanding of their situations, not just to complete a task. Van Manen's (1990) concept of lived relationality is important here, as it emphasises how meaningful relationships can facilitate the development of empathetic understanding. This experience that Frankie is describing is the opposite of Penelope's experience, where Penelope could discuss her nursing values with another who understood and who inspired her. Frankie is seeking this, yet lacks the opportunity to be more autonomous and transform her practice. Regardless, Frankie still demonstrates the journey from student nurse to novice to advanced beginner nurse, which Benner (1984) discusses. She is reflecting on her practice and moving away from a reliance on rules and mimicking others nursing practice (Benner, 1984), and shifting towards making more intuitive, values-based decisions where time to stop and listen to others is at the core of her values.

These narratives illustrate how developing empathy is a transformative aspect of becoming an RN. The participants provided insights into how experiences from clinical practice can alter their self-perception, role, and relationships with others. Their experiences resonate with van Manen's concepts regarding lived space, time, and relationality, emphasising how these elements of our experiences shape our interactions with others. They also demonstrate how Benner's theories on learning from experience manifest in real clinical environments, where students progress from relying solely on rules to making more intuitive, values-based decisions. Transformation occurs gradually and often unfolds during subtle moments of care.

5.5 Summary

Through hermeneutic phenomenological inquiry, my interpretations show how empathy emerged not as a skill to be mastered but as a way of being-in-the-world-with-others. This way of being unfolded through embodied encounters with people, whānau, and colleagues in clinical practice settings. Empathy developed in GEN student participants through the human experiences of being present, being with, and transforming. These themes are not separate processes but are intricately woven as students experience being in clinical placements. Being-present meant slowing down, noticing, and creating space for genuine human connection. It was choosing to sit with a patient or pause before speaking and being attuned without distraction. The GEN student participants began to understand how presence alone could foster empathic nursing practice. Being-with illustrated that empathy often involved sensing when to act and when to step back, recognising the vulnerability of others, and connecting with the tension and pain others experience to create empathetic care. GEN student participants transformed their professional being as they started to reflect more deeply on who they are becoming and began integrating their values, experiences, and understanding of the world into their professional identity. This transformation is slow, ongoing, and often shaped by discomfort, reflection, and relational insight.

In the next chapter, I will discuss phenomenological insights from the research findings, and the findings in relation to existing literature and knowledge. I will also discuss the implications of this study to nursing education, recommendations for future research, and the strengths and limitations of this research.

5.6 Reflection Point

At times, I felt disconnected from the participants' stories and woolly-headed. I was encouraged by the research supervisors to create something creative and express my understanding through a different medium. I took this advice on board and created two pieces of art that reflect what the students were expressing to me. The art represents an expression of my understanding of empathy development and what empathy can look like. This artwork can be found under Figures 7 and 8.

Figure 8, found on page 114, is a piece of art that I created using acrylic paint and brushes on canvas. It was created to visually represent/demonstrate my understanding of empathy within the context of nursing education and practice. To explain the painting, I have illustrated two figures: one light and one dark, seated together under a shared umbrella. I loved the use of colour in art and how colour can be used to visually link emotions and feelings. For this reason, I have selected vibrant colours to give a chaotic background of reds, oranges, and deep shadows to represent emotional turmoil or distress. The artwork's background presents as a metaphorical storm, with the addition of the cloud above the darker figure. The white figure, who holds the umbrella, does not absorb the other’s darkness. Instead, they offer presence, shelter, and emotional safety. The umbrella symbolises a protective, non-judgemental space. It does not take away anything from the others' experience, but it adds shelter, safety, togetherness, presence and someone to be in the storm with. To me, it is being-present and being-with.

Figure 8

Visual Interpretation of Empathy: Shared and Sheltered

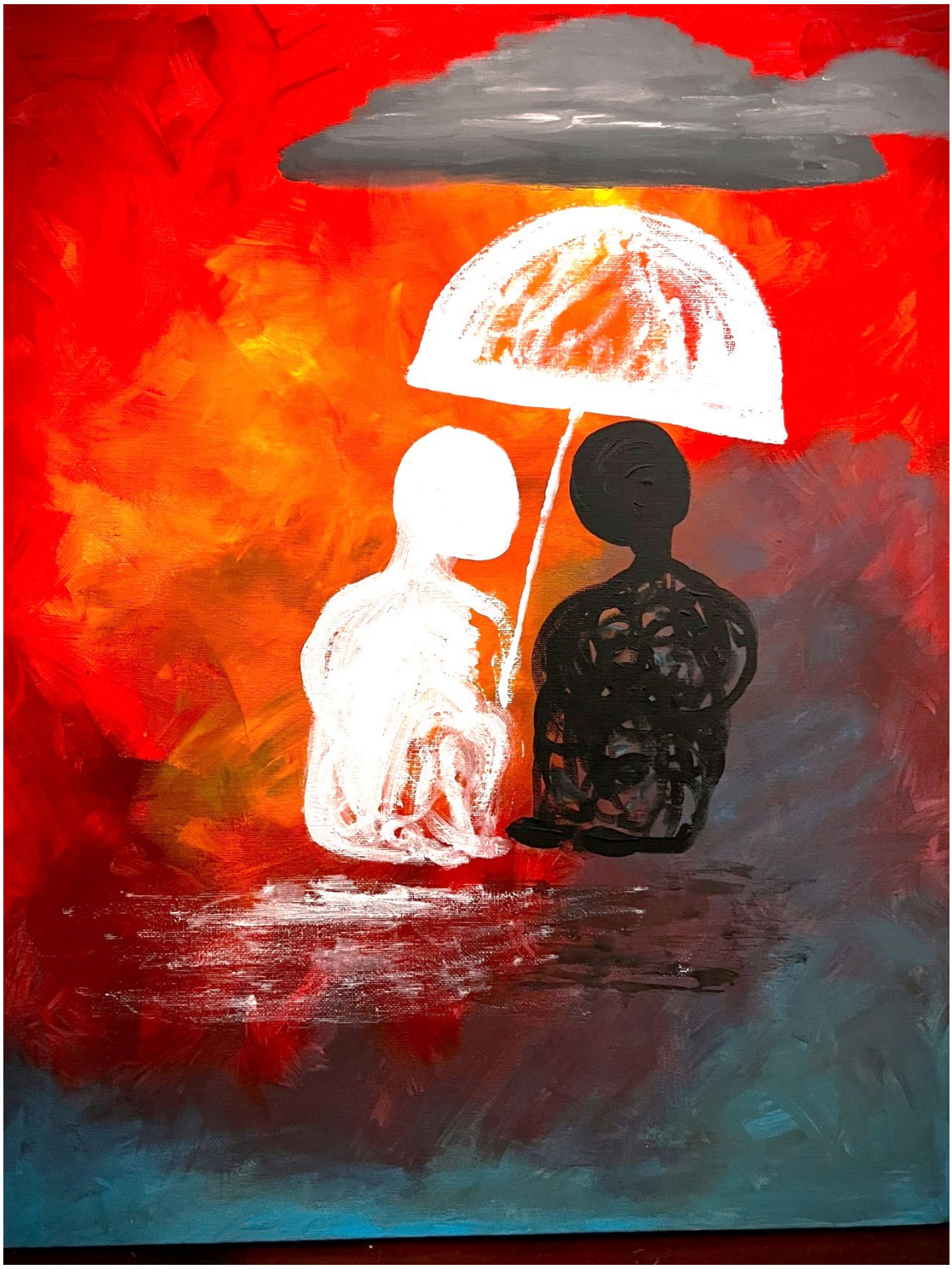


Figure 9

Visual Exploration: The Shared Heart of Empathy

Figure 9, above, is the other piece of artwork I created with acrylic paint, brushes, and felt pens on canvas. The idea of this artwork is to symbolically present the collective and relational nature of empathy. At the centre of the artwork is a large blue heart. The heart is surrounded by four hands reaching inward. The heart is not owned by one, but it is held in shared space. The intention behind this was to indicate that empathy is not an individual act, but a co-created experience between others. Again, I have selected vibrant patterns and flowing lines that radiate outward from the heart. This choice was to evoke warmth, movement, and energy. I have again used reds, oranges, yellows and golds to demonstrate this warmth and radiance, and I have used repetitive patterns.

The white hands are to suggest light, openness, care, and the act of reaching out without taking over. Each hand is contributing to holding space rather than claiming it. This piece was created to communicate that empathy is not about merging with another or absorbing their experience, but about honouring their emotional world while

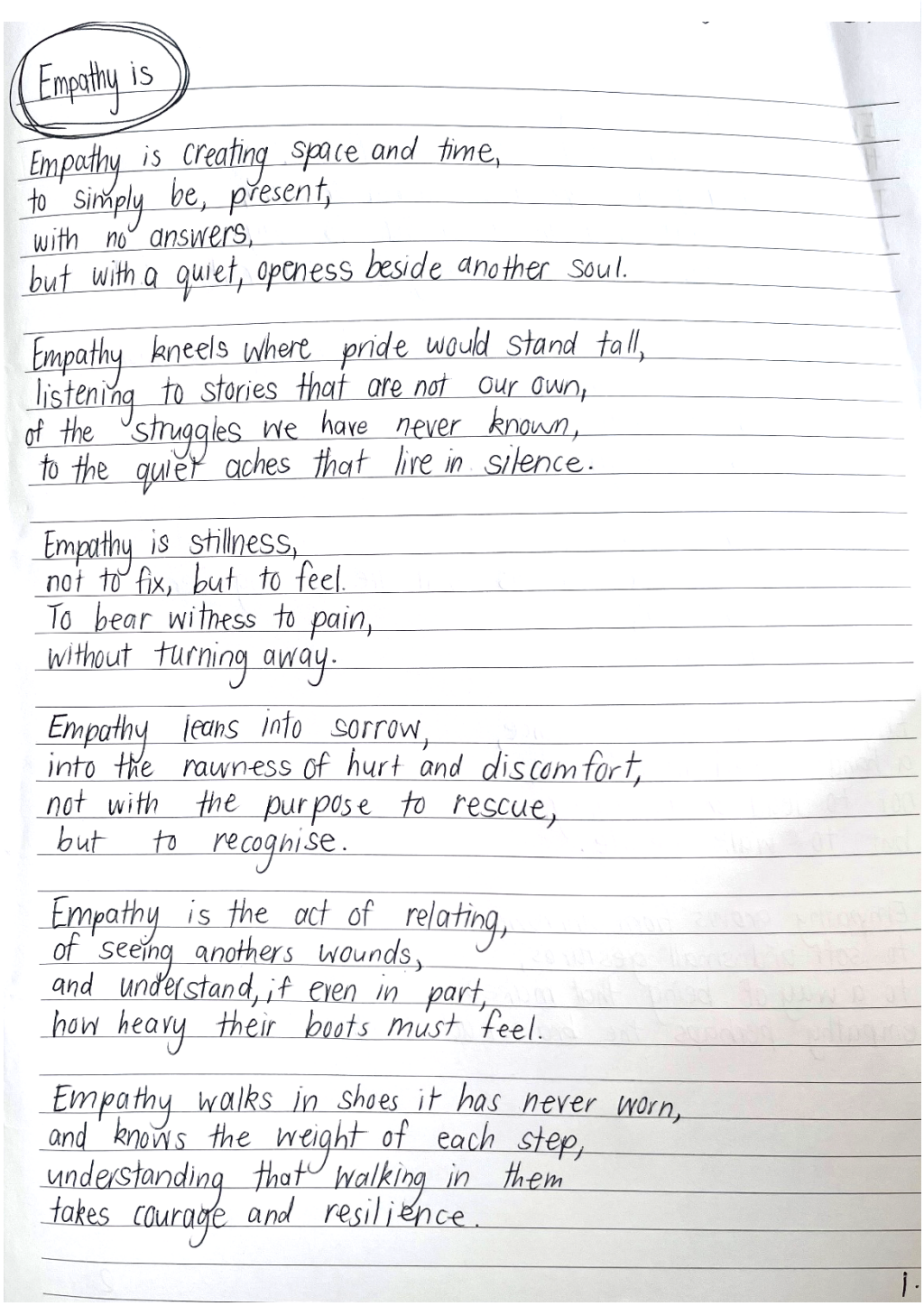
remaining grounded in one's own. It also reflects the importance of collective support and shared responsibility. The central heart serves as a metaphorical space where understanding, emotional safety, and non-judgement can dwell.

Cultural Note: While this artwork may appear to visually resemble elements of Aboriginal or Torres Strait Islander art, it is not intended to represent or replicate any specific cultural tradition or symbolism. The patterns and colours were chosen intuitively and are reflective of personal meaning and emotion. I acknowledge the rich cultural heritage and significance of First Nations art and respectfully clarify that this work is not derived from, nor representative of, any Indigenous artistic practice.

While thinking of ways I could creatively communicate my understanding of empathy in clinical practice, I wrote the poem. The poem titled “Empathy is”.

Figure 10

Poem - Empathy is



Empathy is

Empathy is creating space and time,
to simply be, present,
with no answers,
but with a quiet, openess beside another soul.

Empathy kneels where pride would stand tall,
listening to stories that are not our own,
of the struggles we have never known,
to the quiet aches that live in silence.

Empathy is stillness,
not to fix, but to feel.
To bear witness to pain,
without turning away.

Empathy leans into sorrow,
into the rawness of hurt and discomfort,
not with the purpose to rescue,
but to recognise.

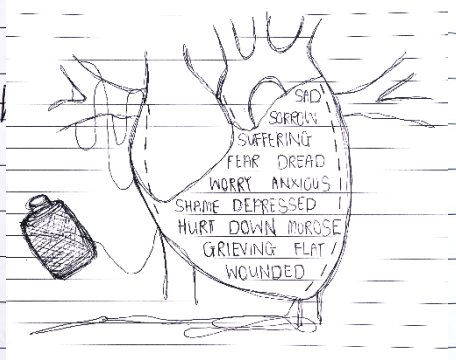
Empathy is the act of relating,
of seeing anothers wounds,
and understand, if even in part,
how heavy their boots must feel.

Empathy walks in shoes it has never worn,
and knows the weight of each step,
understanding that walking in them
takes courage and resilience.

Empathy walks with you
through the rain-filled alleyways of life.
It does not try to stop the storm or rain,
but reaches out with an umbrella to say:
"It is okay. I am here with you. I understand."

Empathy sees the cracks in us that make us whole,
a thread of reassurance,
that weaves it way around,
and pierces through hearts.

Empathy humanises us,
by putting together threads th
a simple reminder,
we are not alone.



Empathy is a mindful presence,
a hand offered in the dark,
not to lead or to carry,
but to walk beside.

Empathy grows from unknowns,
to soft and small gestures,
to a way of being that makes
empathy perhaps the bravest act of all.

Chapter 6 Discussion and Conclusion

> "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." (Maya Angelou, [1928-2014]).

6.1 Introduction

In this study, I have explored the experience of developing empathy for Graduate Entry Nursing (GEN) students in clinical practice settings. In this concluding chapter, I explore a more ontic (concrete) approach, rather than the ontological (essential) nature, used in the previous chapter to explain the essential nature of the phenomenon. This concluding chapter brings together the threads of thought and the themes woven throughout the students' voices, addressing the research question: **How do GEN students in Aotearoa New Zealand experience the development of empathy in clinical practice?**

In this chapter, I provide a brief overview of the study. It then draws on the lived experiences of participants to discuss how personal, relational, and contextual factors across clinical settings shape empathy and its development in GEN students. The findings were compared to the existing literature, which offers insights into the complexities of empathetic practice within nursing education. I have discussed the implications for clinical practice below each of the three themes and provided recommendations for practice, education, and future research. Moreover, in this chapter, I highlight the multiple strengths and limitations of the study. To conclude, I offer a final overview of the study, the importance of this research, and a summary of the findings from this study.

The opening quote of this chapter is a well-known saying by Maya Angelou; however, the origin of the quote is debatable. It is a quote that came to mind as I was interpreting and making-sense-of the participants narratives. It resonated with me, and this is what the participants were saying. They were being-present, being-with-other, and transforming their nursing practice to embody an empathetic approach that allows others to feel seen, heard, and connected with.

6.2 What do the Stories Mean?

Seven GEN students volunteered to participate in this study, and all consented to be interviewed via Microsoft Teams. Three themes emerged from the interviews: Being-present, being-with and transforming. The findings illustrate that GEN students did not view empathy as a technique or skill to be applied. The GEN students spoke of empathy as a lived, unfolding process that was rooted in attunement, presence, slowing down, pausing, connecting, and recognising shared humanity. Babaii et al. (2021) explain that empathy is a nursing attribute that can be characterised as the ability to walk alongside another human in times of grief, pain, and discomfort. By showing up with presence, being slow, pausing, and connecting, the GEN students demonstrated empathy, as explained by Babaii et al. (2021). They could walk alongside others in their times of grief, pain, and discomfort, whilst recognising a shared humanity.

The insights from the GEN students disrupt a dominant framing of empathy as a 'skill set' or a 'checklist' of behaviours that requires a cognitive aspect. GEN students described empathy as a way of being that was inherently part of being human. This aligns with a critique by Decety and Cowell (2015), who explain that empathy is a relational capacity, not a 'skill'. While the working definition of empathy for this thesis, as formulated by literature at the time, begins by stating empathy is "a cognitive attribute", I now disagree with this. My assumption was that empathy would appear in the narratives as a cognitive recognition, a way of "knowing what the patient feels." But as I circled back and forth through the narratives, my interpretation shifted, and I began to realise this was not entirely what the GEN students were suggesting. They were suggesting that empathy is inherently part of being human and can be cultivated through quiet, subtle gestures, pausing, listening, and being attentive. Keutchafo et al. (2022) refer to these characteristics as non-verbal communication. Empathy revealed itself through the narratives as a way of being-in-the-world with others, through lived and relational togetherness. The GEN experiences demonstrate how empathy is enacted through embodied attunement, rather than cognitive thinking (Tomkins & Simpson, 2015).

The following section discusses the three themes: Being-present, being-with and transforming. I have ordered this section first to explore each theme to gain

phenomenological insights, then consider how these insights connect with or challenge existing literature, and finally, examine the implications for education and clinical practice.

6.3 Being-Present

6.3.1 Phenomenological Insights

The theme of being-present can be interpreted as how GEN students develop empathy in real-world settings, by being slow, relational, by offering space, time and by showing up to be present. Heidegger speaks of silence not being a void, but a place of potential meaning that can only be accessed through empathetic, attuned presence (Agosta, 2014). However, the narratives of the GEN students do challenge the idea of empathy as a discrete skill to be mastered, instead illustrating empathy as a slow, relational, and attuned understanding of another's world. I would push this further and suggest that there are broader phenomenological understandings of presence as an embodied and relational way of being, rather than a cognitive or procedural act. As George described, "it's kind of something you think about and is part of being human, but it's not something you think about specifically. OK… 'now I will be empathetic.'" [George]. For George, empathy was experienced as intuitive and pre-reflective. This was part of her way of "being human." In the Heideggerian sense, George was open to the lived reality of the other (Neubauer et al., 2019). Presence is a relational phenomenon, where pausing, slowing, and 'being-there' create a space for meaning to emerge.

Being-present presents as a relational attunement to the other. The GEN students described empathetic attributes from the RNs they worked with. In this sense, role-modelling ways-of-being greatly influenced the development and understanding of empathy tendencies for GEN students. "They were available…" [Summer]. Summer's narrative reveals an emerging empathy as situated attunement and a form of being-there-in-the-moment, as the preceptor remained attuned to the patient rather than immediately moving on to the next task. These experiences resonate with van Manen's (1990) concept of lived relationality, where care is embodied in gestures, pauses, and ways of being. In this sense, being-present involved having time. van Manen discusses the concept of time and explains that, through Heidegger's lens, being-present means experiencing the world by living in the now (van Manen, 2014). According to Heidegger,

time is cyclical rather than linear (Heidegger, 1962). A moment is shaped by the past, which is no longer present, and extends into the future, which is not yet present. Similarly, GEN students require time in clinical practice to support their learning.

Similarly, Frankie had a preceptor who demonstrated acts of relational care that helped her to develop empathetic insights: “That kōrero or that conversation was like his warmth and the way he talked, his smile, he was very relaxed” [Frankie]. I have interpreted this sentence to mean, being-present is about embodied attentiveness, pausing and attunement to the patient’s lived world. Talking to them in times when they know they are scared or in pain. In this sense, I have interpreted Frankie's experience to reveal empathy as the subtle act of relational care that emerges through kōrero (conversation). van Manen (2014) addresses this idea, where care is found in small acts of presence. Examples of these small acts of presence can be how long one pauses, whether one chooses to enter a space or remain outside (van Manen, 2014).

These moments illustrate how empathy is lived and practised in quiet, and often unnoticed ways. Both Frankie and Penelope observed the role of presence when their RN preceptor gave full attention to patients, allowing time for conversation to unfold naturally. The students notice that being-present, though often undervalued, is an essential aspect of empathetic practice in healthcare, as it involves the capacity to engage meaningfully with patients, focusing on their needs, their world, and minimising distractions during interactions.

6.3.2 Literature Discussion

These phenomenological insights challenge existing definitions of empathy as being primarily cognitive (Reniers et al., 2022). Being-presents asks a busy world to stop, slow down, and tune in to the world of another (Decety & Cowell, 2015). Being-present does not ask one to turn on cognitively and run through a checklist of “how to be empathetic.” This is known as cognitive empathy, where, as explained by Reniers et al. (2022), it involves constructing a model for the emotional states of others. This does not align with how being-present was interpreted. However, Reniers et al. (2022) go on to suggest that cognitive empathy is linked with an attribute called perspective-taking. This is important to note as a study by Guidi and Traversa (2021) advances the notion of perspective taking and raises that *‘empathic concern’*, focuses on the notion of ‘concern’ for another,

and a genuine interest towards their experience through ‘engaged curiosity’. They explain that engaged curiosity is an *attitude* that comes with the action of welcoming and acknowledging the lived experience of another (Guidi & Traversa, 2021; Halpern, 2014). It can then be argued that being-present is aligned with the notion of ‘engaged curiosity’ where a genuine interest towards their experience of another comes with the action of welcoming and acknowledging the lived experience (Guidi & Traversa, 2021; Halpern, 2014; Reniers et al., 2022).

Kwame and Petrucka (2021) highlight the challenge in clinical environments of balancing task-oriented care with the relational depth required to foster genuine connections with patients. Moreover, Kwame and Petrucka (2021) explain that patient-centred care is significantly reduced when the focus of a nurse is on completing tasks or institutional routines. This too highlights that being-present is about the quality of engagement that encompasses the ability to be slow, have time to be still, and attune to the ‘moments-with-another' (Hobbs et al., 2020). van Dijke et al. (2020) would argue that empathy is co-created, meaning it requires participation of the giver and the receiver. Research by Tolosa-Merlos et al. (2023) suggests that the attitudes of nurses during interactions can determine how therapeutic the relationship is with another person. Bryne et al. (2023) suggest that interventions promoting relational building/therapeutic relationships must first address the attitudes, knowledge, skills, and behaviours of others. These research findings confirm what is seen in being-present, where time and slowing down are key factors required. The students also discussed attunement, which can be viewed as a co-created form of empathy. The GEN student participants found that being present did not require speaking for patients to feel seen or heard, which aligns with research by Tunks Leach et al. (2025), who identified non-verbal communication as a valued dimension of empathetic care.

By actively engaging in moments of presence with patients, students found opportunities to learn and develop relational intelligence (Kwame & Petrucka, 2021). Hajibabaee et al. (2018) explain that nursing students with greater emotional intelligence and empathy have better relationships with patients and their families. Research shows that the emotional intelligence of student nurses changes throughout their years of study in a nursing programme (Budler et al., 2022). Sharon and Grinberg (2018) suggest that the emotional intelligence of nursing students increases in their

second year of study. Emotional intelligence was also seen to correlate with coping with the dimensions of higher-education-related stress (Xu et al., 2023). Therefore, by being-present and actively engaging with patients, the students' emotional intelligence was developing. Research by Xu et al. (2023) suggests that higher emotional intelligence facilitates better patient health outcomes.

While GEN students did not frame presence in terms of outcomes, as this was not the focus of the research question, existing research suggests that these subtle practices correlate with improved trust, satisfaction, and health outcomes for patients (Eklund et al., 2019; Kwame & Petrucka, 2021). Similarly, Krist et al. (2017) found that patients' health outcomes improve when they feel their voices are genuinely heard and engaged with. This relational dynamic aligns with research suggesting that empathy can lead to better healthcare experiences and patient satisfaction (Halpern, 2001; Sinclair et al., 2016). These studies echo the experience of the GEN students, where empathy arises less from slow, relational attunement. Research supports the notion that reduced nursing workloads enhance empathetic actions (Waterfield & Barnason, 2022). However, being-present highlights a tension between institutional pressures and the relational aspect of care (Todres et al., 2009; Watson, 2008). Students recognised how role-modelling shaped their understanding of presence, yet spending time at the bedside is not always a reality in clinical placement facilities with high, demanding workloads, despite studies showing that reducing nursing workloads enhances empathetic actions (Waterfield & Barnason, 2022).

6.3.3 Implications for Clinical Practice and Education

The findings from this study raise important questions for nursing education and practice. In clinical practice, empathy cultivation needs to move away from procedural checklists and cognitive models and move towards being-present, listening, showing attentiveness, and being slow. It is the small, often unnoticed acts that are key to how empathy is communicated and received. The development of empathy is influenced by the relational behaviours that GEN students see in their RN preceptors. The high workloads of RNs and the task-focused environments can undermine the capacity for presence and, therefore, empathy to be developed.

In nursing education, a shift is needed in the curriculum from treating empathy as a competency to seeing empathy as a way of being in clinical environments. Experimental learning, such as simulations, journaling and reflective dialogues, could support students in tuning in to others rather than reacting to them. The study suggests that emotional intelligence develops over time, and with clinical experience comes improved ways for students to respond to and manage stress, thereby putting them in a better position to act with empathy. Moreover, students need structured opportunities to observe and discuss relational behaviours of their predecessors to unpack what they have seen and reflect. Empathy development requires space, both physically and emotionally, for presence to emerge.

6.4 Being-With

6.4.1 Phenomenological Insights

The theme of being-with is closely related to the theme of being-present, yet it represents a distinct dimension of empathetic practice that warrants separate attention. Being-present, as discussed above, referred to one's ability to fully engage in the moment, without distraction, allowing empathy to arise from a place of slow, relational attentiveness. It was a co-created space, where non-verbal communication, slowing down, pausing, and focusing fully on the other allowed empathy to emerge. Being-with extends this attentiveness shown in being-present, and reaches out into the relational space of empathy, where empathy emerges through interpreting, perceiving and connecting with the mood, emotions and feelings related to the lived experience of the other. In Heideggerian terms, this reflects the essence of *Mitsein* (being-with), where one dwells with the joy, fear, and suffering of another (Agosta, 2014). While being-present positions the nurse to meet the patient attentively, being-with enables understanding to take shape through interpretation, and connection to the emotions that lie with an experience. Again, this illustrates *Mitsein* (being-with), where care emerges authentically in moments of connection and relational engagement.

Kaia saw that listening and acknowledging the client's concerns allowed for a moment of connection and calmness. Heidegger (1962) talked about this intention of leaping into help fix something for someone, which can unintentionally disempower them from their own possibilities and undermine their dignity and autonomy (Dewar et

al., 2023). Phenomenologically, empathy presents as both a resonance with another's emotional state and the ability to interpret. It is about a willingness to dwell in another's world, to listen to their perspectives, and to listen and respond to their lived reality rather than to one's assumptions (Gadamer, 2004). The students' reflections illustrate how empathy emerges as the act of interpreting and perceiving the emotional world of another, and how this act can create a bridge across differences that enables connection. Penelope initially felt distanced from a patient whose life experiences were unlike her own. Yet, she recognised shared emotional ground, such as stress and bodily change, that enabled the gap of difference to be bridged. This is a movement, or a shift, that exemplifies Gadamer's (2004) notion of "fusions of horizons" where empathy did not rely on sameness of a situation, but on openness to the unfamiliar. Similarly, George's description of 'taking a step back' in mental health practice unfolded a shift from doing-for to being-with, where she can focus less on tasks and more on the client's emotional world. This movement towards being-with shifts from a surface-level interaction to a place of interpretive care, where George sought to understand not only what the client is doing, but what their behaviour or silence might reveal about their inner world (Oewel et al., 2024).

van Manen speaks of small acts, such as a gentle touch given to a patient during a procedure or to calm (1990). Frankie's actions portray this. When she noticed that a patient looked frightened, she connected with that experience and sought to comfort the patient through their fear. Frankie's simple act of "petting her hand" when a patient was frightened aligns with van Manen's (1990) concept of lived relationality and how small gestures can signal comfort, care, and connection. Tomkins and Simpson (2015) emphasise that attunement is an embodied sensitivity to the emotional, existential, and relational states of others, which the GEN student describes as a willingness to sit in discomfort, distress, and vulnerability. In this way, empathy was not a technique but a way of existing. Phenomenologically, being-with affirms empathy as both resonance and interpretation. It is an openness to how the world appears and is perceived by others (Gadamer, 2004). Brown (2021) supports this, noting that empathy is grounded in boundaries and presence rather than projection or comparison.

Being-with extends beyond the patient or client and reaches out to the whānau (family). Mārama's experience in the paediatric unit shows how being-with the whānau

(family) is also part of creating a relational space, where connecting with and understanding the emotions of the broader network of family and friends is just as important as the patient or client. In this way, being-with affirms empathy as a relational concept that unfolds across the interconnected lives of those involved in care. In this way, empathy is an ongoing, dynamic process that evolves through dialogue and reflection, allowing for the "fusion of horizons" (Gadamer, 2004). This notion of fusion of horizons suggests that empathy is a continuous process of engagement and transformation, where students expand their understanding of the world through their encounters with patients, suggesting the process is not linear but a process that unfolds through embodied relational experiences within the student's exposure to clinical practice (Gadamer, 2004).

Moreover, Penelope demonstrated Verstehen or understanding of the patient's experience during clinical practice (Tomkins & Simpson, 2015). Penelope explained that she could see the patient reaching for the blanket and recognised a shared feeling with the patient, because she was in a place where she could really see the patient. Heidegger (1962) would argue that this is a fundamental aspect of human existence; to be open to the world and others in a way that acknowledges their lived realities, which are often unspoken but deeply felt. Penelope may not be close to the patient physically, but she is near in a sense.

6.4.2 Literature Discussion

Nursing practice involves constant engagement and communication with others, which can often bring out a wide range of positive and negative emotions, which, for nursing students, can be challenging as they begin learning to manage these emotions (Al-Amer et al., 2022). However, the GEN students demonstrated resilience and the ability to bounce back from adversity, embracing uncertainty, discomfort, and leaning into situations of connection (Aryuwat et al., 2023; Kaldal et al., 2018). The theme of being-with emphasises the importance of interpretation in empathetic care, even during times of discomfort and negative emotions. Students, like Penelope, moved past disconnect and towards understanding the patient's experience through shared emotional experiences, such as stress and bodily change. A study by Reniers et al. (2022) suggests this move, or shift, is known as cognitive empathy. Cognitive empathy can be defined as "the ability to construct a working model of the emotional states of others and

importantly entails the comprehension of another person's emotional experience." (Reniers et al., 2022, p. 945258). Cognitive empathy is criticised in literature for the risk it poses on obscuring an experience, rather than sitting with and listening to a patient's experience, which I argue is not 'being-with' (Guidi & Traversa, 2021). However, Reniers et al. (2022) discuss another process in cognitive empathy known as 'perspective taking'. Perspective taking creates a metaphorical bridge of understanding. I would argue that perspective-taking is being-with, as it involves the interpretation of an experience and the ability to connect despite differences. Penelope was able to connect with the patient by imagining what the patient might be feeling by intuitively putting herself towards a place where she was closer to the patient's position since she had never experienced these exact situations herself (Reniers et al., 2022), which is perspective taking.

Agosta (2014) describes empathy as a multidimensional field of connection, interpretation, and listening, where genuine, authentic human connection and understanding become possible. This understanding of empathy shows why the themes of being-present and being-with are related but remain distinct. Presence creates conditions for openness, while being-with requires stepping into the relational and interpretive space where meaning emerges. Ringwald and Wright (2021) suggest that it is our shared being that fosters a sense of togetherness, which facilitates empathy through relational presence. Halpern (2003) frames this as clinical empathy, where understanding is an interpretive act of attunement. Moreover, it is a critical factor in delivering safe, individualised, high-quality care, which can lead to better patient outcomes (Halpern, 2003; Winter et al., 2022). Halpern (2003) and Winter et al. (2022) exemplify this again by explaining that clinical empathy can lead to fostered relationships and shared understanding.

The GEN students described extending empathetic care beyond the patient and offering this to the wider relational network. Mārama's narrative of working in paediatric care emphasised the importance of including the whānau (family). This aligns with Wilson et al. (2021), who describe a Māori-centred model of care to involve whānau (family), to promote culturally safe care, and help to address inequities in health care. By recognising the emotional needs of the whānau (family), Mārama demonstrated how empathy extends beyond the patient and involves an openness to the emotional world of those connected to the patient. This recognition supports the key elements of a

Māori-centred model of relational care, which Wilson et al. (2021) describe as grounded in “whakawhanaungatanga (the process of building relationships), using tikanga (cultural protocols and processes), informed by cultural values of aroha (compassion and empathy), manaakitanga (kindness and hospitality), mauri (binding energy), wairua (importance of spiritual wellbeing)” (p. 3539).

The nature of folded time, where a patient’s emotional and psychological experience extends beyond the clock, becomes an essential aspect of empathetic practice (Crandall et al., 2022). For the nurse, “work” ends at the end of their shift, but for the patient, their situation continues 24-7 (Oben, 2020). This insight into the lived time and experience of patients was also described by GEN students, who noted a shift from task-oriented care to a more relational form of care that respects the humanity of the patient at every moment. GEN students experienced empathy as a shift from task-oriented care to relational care, that was expressed as being a change from “doing for” to being-with (Oben, 2020). George’s narrative demonstrates this shift from doing-for, to being-with, and dwelling-in.

George’s narrative describes her “taking a step back” in mental health practice, which shows this shift from “doing” to “stepping back” and dwelling. George moves from task orientation towards interpretive care, seeking to understand the silence and the client's emotional world (Oewel et al., 2024). Moudatsou et al. (2020) emphasise the importance of maintaining a focused approach on the person and their underlying feelings, as this fosters a safe patient-nurse relationship and enhances health outcomes. Malet et al. (2022) explain that attunement and reflection are part of the relational process. Although the students did not describe or tie their experiences to outcomes, literature demonstrates that their shift towards being-with does come with improved health outcomes.

6.4.3 Implications for Clinical Practice and Education

The theme of being-with emphasises empathy as a relational engagement that requires attentiveness, interpretation, and openness to the emotional world of others, even when unfamiliar or uncomfortable. For nursing education, this suggests that empathy cannot be reduced to a competency checklist, but again, it is a concept that requires time in clinical practice. GEN students reveal that the movement from “doing-

for" to "being with" is a necessary shift to move from being task-focused to relational in their care. Environments need to value time to dwell with patients and reward relational care practices, such as staying with a patient during times of emotional distress, without feeling the need to rush off. For clinical practice, it is evident from the literature that relational care is linked with improved health outcomes. This highlights the need for supportive staffing and workload policies to be revised. Organisations need structures that protect time and lighter patient workloads to enable nurses to dwell with patients at the bedside, rather than complete tasks for them. The need for lighter workloads when learning and developing in clinical practice settings stems from the time required to transition from doing-for to being-with. There is a need for recognition of the fact that empathy cannot flourish if nurses and nursing students are overwhelmed by tasks and time pressures. The study also shows that empathy is fostered through perspective-taking, even when GEN students have not shared the same life experiences as their patients. In both education and clinical practice, team discussions should involve reflections that move beyond 'fixing' to relational understanding practices. Moreover, empathy moves beyond the individual and includes the whānau (family). Culturally safe practices and relational models of care, such as Māori-centred models of care, should be integrated into curricula.

6.5 Transforming

6.5.1 Phenomenological Insights

The theme of transforming emerged as a thread that was woven throughout the narratives from the GEN students' experiences in clinical practice. While the two previous themes —being-present and being-with —describe how empathy is enacted in moment-to-moment encounters, transformation is the broader process of becoming a nurse. Transforming speaks to how GEN students evolve into empathetic, values-driven practitioners (Yu et al., 2022). The GEN student participants described how clinical practice settings were sites of transformation, where experiences helped them apply theoretical knowledge to practice, they witnessed role modelling, and from this, they could engage in reflection. Summer exemplifies the importance of having time to reflect in clinical practice.

Summer used reflective questioning to ask herself, “Why did they do it in that way?” which shows she is thinking about and using reflective inquiry to discern the kind of nurse she wants to become. Reflective practice, as described by Machost and Stains (2023), is the process of actively, persistently, and carefully considering any belief or knowledge. Akin to Summer, Frankie spoke about her thoughts towards the future nurse she wants to be. Frankie speaks about moving away from ‘imposter’ mode, where she does what other nurses do to ‘fit in’, to seeking to be in a position where she can be autonomous and practice nursing in a way that allows her to uphold her own values. Frankie wants to be acting empathetically in her practice, and spend the time being with-others and listening to them. van Manens’ (1990) concept of lived relationality is important here, as it emphasises how meaningful relationships can help the development of empathetic understanding. Such is true for Frankie.

Students identified observation, role models, reflective questioning, and patient encounters as key sites of transformation. Witnessing empathetic practice, or at times, an absence of empathic practice, facilitated a space for students to form and refine their own empathetic stance. Habib et al. (2025) discuss’ how this can be ‘vicarious control, where people, students, can take on the attitudes of others around them. Vicarious control and role modelling are therefore part of the student’s transformation process (Habib et al., 2025). Habib et al. (2025) suggest that those in positions of authority set examples and behavioural standards for students undergoing their education, whether they are aware of it or not. This example is exemplified when students spoke of experiences that involved noticing a nurse’s positioning by the bedside, sitting close to foster trust, or choosing silence in moments of emotional intensity. The embodied nature of empathy was made evident in Sam’s account, with the empathetic leadership skills demonstrated by a nurse unit manager. Sam’s experience speaks to the idea that, whether they are aware of it or not, those in positions of power role model ways of being that assist students to transform their nursing practice.

GEN students described moments of not knowing what to do, feeling unsure or questioning their role while in clinical placements. I did not interpret these moments as signs of failure, but rather as signs of transformation and growth. Heidegger (1962) suggests that these unsettling experiences are foundational to existential growth, challenging us to confront assumptions and re-evaluate our understanding of care,

responsibility, and being-with others. Russo-Netzer (2025) similarly refers to this as ‘positive anxiety’, where experiences of initial distress can become powerful sites of growth and adaptation. This transformation was not imposed externally but emerged internally, through internal reflective dialogue. However, this was not the case for all GEN students. Participants such as Mārama and Penelope showed that empathetic growth extends beyond being-present in the moment of care, or being-with someone through connection, but it extends to thinking through and processing experiences afterward, outwards. GEN student participants described how conversations with clinical educators (CEs) or their RN preceptors helped them to explore their feelings and values openly in a supportive space. In this sense, the transformation of the GEN students was an ongoing process from being a passive learner to becoming an attuned beginner practitioner. Benner (1984) addresses this concept, describing the development of nursing expertise as involving engagement with patients and their unique situations, followed by the learning to interpret and respond appropriately. Reflection is the site for this transformation (Benner, 1984).

6.5.2 Literature Discussion

The GEN student's transformation was interpreted as a gradual, non-linear process, which is an idea supported by Hayes et al. (2007), who state that change can be gradual and even incremental, but there can be periods of disruption and instability that can change these growth patterns. McHugh and Lake (2010) and Benner (1984) further this and discuss how development in student nurses is a cyclical, ongoing process. It takes time. Benner (1984) would refer to this as a transition from novice to beginner. However bumpy this road of transformation from novice to beginner might be, the narratives from the GEN students explain the role of clinical placements as powerful sites of transformation during the student's nursing education. Habib et al. (2025) speak to this and state that empathy is an evolving process that comprises accepting existing norms and adjusting practice to recalibrate emotional responses to maintain empathic practice. The findings of this study reveal that GEN students came to recognise empathy by witnessing and embodying subtle relational practices, as supported by van Dijke et al. (2020). However, the relational dimensions of empathy receive less attention in both theoretical and empirical research (van Dijke et al., 2020).

For the GEN students, transformation and developing empathy began to take shape through a growing awareness of how space is inhabited and through witnessing role modelling (Baldwin et al., 2014). Baldwin et al. (2014) and Heggestad et al. (2022) mention how the role modelling of empathy in clinical practice is essential in developing such skills. Students were insightful, sharing insights such as sitting close to a patient fosters openness, trust and a subtle but important shift from task-focused care to relational, patient-focused/centred care (Kwame & Petrucka, 2021). However, there is research by Dossey and Keegan (2016) that shows even while engaging in task-oriented activities, with a caring presence, nurses can still provide therapeutic care. Pausing and presence become non-verbal gestures that signal openness and attentiveness to the patient. Tunks Leach, et al. (2025) would agree, as their research identified non-verbal communication as a valued dimension of empathetic care.

Literature suggests reflective practice is fundamentally important to the development of nursing students' clinical skills, ways of being and their lego-ethico-professional development, in addition to the effectiveness of their clinical skill application (Yang, 2025). Barchard (2022) discusses how lived experiences challenge and refine students' emerging professional identities, prompting them to reflect upon and shift from passive learners to beginner professionals. This is also known as the 'adaptation phase'. The adaptation phase is the time when nursing students transition from being novices to becoming expert beginners (Benner, 1984). This is also a transitional step necessary for student nurses to succeed in their future nursing careers (Benner, 1984; Ernawati & Bratajaya, 2021).

This supports this idea of acceptance and adjustment as part of the transformation process in clinical practice (Habib et al., 2025). The experiences of GEN student participants resonate with the literature on reflective practice, which has long been identified as a foundational step in professional transformation. Machost and Stains (2023) explain that reflection requires active, persistent, and careful consideration of experiences, which supports the accounts of slow and evolving growth seen in the GEN student participants. Schön's (1983) notion of a reflective emphasis is that the practice of reflection allows students to evaluate experiences and adapt their practice to align with professional values. Yang (2025) explains that reflective practice in nursing has become a core pillar for students to consider what they observe in

practice, evaluate the effectiveness, and how to readapt their practice to one that aligns with their individual empathetic values.

This was particularly evident in Penelope's experience, where she critiques the limitations of classroom discussions on empathy, and instead emphasises the importance of lived experience and supportive mentorship from her CE. Mentorship and role-modelling emerged as crucial in this process, which aligns with findings from Baldwin et al. (2014), Azadian et al. (2024), and Konow Lund et al. (2018). The CE becomes a relational anchor who can offer space for students to explore their values and integrate them into their professional identity. This process of becoming and transforming aligns with Benner's (1984) novice-to-expert framework, where the professional identity of student nurses is said to develop through situated encounters that gradually shape discernment and clinical judgement.

Konow Lund et al. (2018) conducted a study that demonstrated nursing students learn from observing RN preceptors, the ways in which they work, and the adaptations needed to fit the emotionally demanding work of nursing and the nursing profession. For Sam, this extended into observing empathy in leadership. Through calm communication, emotional attunement, and inclusive leadership, the manager created a workplace environment where care was enacted at every level. Tomkins and Simpson (2015) argue that leadership grounded in presence and care fosters psychological safety and shared understanding, both of which are qualities for workplace satisfaction and for high-quality patient care.

The ability to talk about clinical experiences with a mentor fostered the development of empathy and assisted in the development of the student's professional identity as the students were able to be open about how they feel and how they go about a situation with another who understands and can offer guidance and support (Kurt et al., 2023). Such opportunities can foster self-awareness and cultivate empathy in students. Du et al. (2022) explain that when a nurse is clear about their own values, they are more likely to approach their patients with compassion and understanding. Working and conversing with professional role models, such as RNs, leaders, and CEs, GEN students were placed in a position to build a personalised framework for their own empathetic clinical practice.

6.5.3 Implications for Clinical Practice and Education

The findings from this study suggest that nursing education must create conditions where transformation is recognised as necessary for the success of future nurses. These conditions must involve a supportive environment where role models of empathic care are present, time is abundant, and where internal and outward reflective dialogue are welcome. In clinical practice, time is needed for self-reflection to allow students to consider preconceived ideas and their expectations, thereby best preparing themselves for future situations or comparable scenarios (Benner, 1984; McHugh & Lake, 2010). Moreover, having time to talk about clinical experiences with a mentor is shown to support the development of the student's professional identity, as the students were able to be open about how they feel and how they go about a situation with another who understands and can offer guidance and support (Kurt et al., 2023).

Being able to reflect on challenging situations with someone who values and understands the situation can help students process their emotions, make sense of complex situations, and foster the development of empathy (Lee et al., 2018). Therefore, clinical practice and nursing education need to create space and opportunities for reflective practice to facilitate a movement from task-oriented care to one of relational engagement. In clinical practice, this requires organisational cultures to recognise the importance of relational care, rather than measuring empathy as a competency to be measured and assessed. Moreover, RN preceptors need their role in the student's transformation to be recognised, with reduced workloads to educate students, and training in mentorship to enhance their role in fostering empathy in GEN nursing students.

While the GEN students said that the GEN programme curricula introduced concepts such as empathy and cultural safety within classroom discussions, participants in this study emphasised that these ideas are most powerfully understood not in the classroom but in the clinical space. It was the time spent in clinical practice settings that facilitated an environment for students to witness, reflect, relate to, and apply.

6.6 Strengths and Limitations

6.6.1 Strengths

This study offers several strengths.

- The study addresses a noticeable gap in existing research. This is the first study, to my knowledge, to explore the lived experiences of empathy development among GEN students within the context of Aotearoa New Zealand, making the findings original and locally relevant.
- The research methodology, hermeneutic phenomenology, ensured the collection and interpretation of participant narratives were meaningful and were supported by a diverse participant group that enhanced the relevance of the findings across diverse cultural and social backgrounds.
- The study had Māori participation, which strengthens the voice of Māori in research and research outputs.
- The timing of the research is significant given the recent introduction of GEN programmes in Aotearoa New Zealand, which makes the insights from this study timely and applicable to current education frameworks.
- The study challenges the traditional views of empathy as merely a clinical skill or attribute by repositioning it as a fundamental way of being, which has clear implementation for both nursing education and practice.
- The research findings can directly inform curriculum development by suggesting the addition of structured reflection activities, by involving current or past GEN students in curriculum development workshops, by using student narratives and storytelling in teaching time, and by including Māori-centred and Pasifika models of care into the curricula to support the development of empathy in nursing students in a way that resonates with their lived experiences.

6.6.2 Limitations of the Study

This study has several limitations. I begin by bullet-pointing the limitations of the study before discussing the limitations of the GEN programme and empathy development, and limitations in clinical practice for empathy development

- All participants were recruited from tertiary institutes in the upper North Island, limiting the geographical diversity of experiences. As a result, the study does not fully capture the perspectives of GEN students across Aotearoa New Zealand. A more geographically diverse population would serve to explore further whether the lived experience differs from those undertaking clinical placements in the upper North Island of Aotearoa New Zealand.
- Most participants were interviewed during their first semester of their second year of study. This means the narratives shared were based on experiences from their first year of study. This restricts insight into how empathy develops throughout the entire programme, particularly in the final semester when students may have gained more clinical exposure and personal growth. Consequently, the study is limited to the experiences gained prior to the date and time of the interview, as no participants were interviewed in their final semester prior to becoming an RN.
- All participants were interviewed online via Microsoft Teams. While this approach was efficient in terms of time, cost, and accessibility, it limited the depth of rapport that could be established. Face-to-face interviews may have allowed for a greater sense of connection, comfort, and care, which is particularly important in research exploring emotionally rich experiences such as empathy.
- None of the participants identified as Pasifika. This limited the study's ability to understand the experiences of empathy development among Pasifika GEN students. The lack of representation may reflect the low enrolment of Pasifika students in GEN programmes. According to Statistics New Zealand (n.d), 8.1% of the population in Aotearoa New Zealand identify as Pasifika.
- Underrepresentation of Māori and Pasifika voices as they are vital in shaping culturally responsive education and a more equitable health workforce (Wilson et al., 2022). Increasing the participation of Māori and Pasifika may have strengthened the cultural relevance and impact of this research on nursing in Aotearoa New Zealand.
- My own position as a researcher influenced this study. My beliefs and values inevitably shaped how I interpreted the participants' stories. By engaging in reflexivity and examining my pre-understandings before data collection, I sought

to remain aware of these influences and minimise their impact on the findings; however, I still recognise this as a limitation

6.6.3 Limitations in Clinical Practice for Empathy Development

The findings from this research raise questions about how healthcare systems can support spaces for presence in environments often governed by time scarcity and task-oriented care. Research demonstrates that there are many factors within a health care environment that can impact on the ability for nurses to act empathetically, such as a poor ability to relate to and understand patients, secondary to a lack of life experience or a lack of contact time with patients, previous negative experiences with patients, high workloads, desensitisation, workplace burnout, work related stress, and workplaces that feel hostile (Yu et al., 2022). In clinical environments where time pressures are high, the ability to "be present" may sometimes conflict with the need to complete tasks quickly, to enable the ‘work’ to be completed promptly (Yu et al., 2022). Research by Shannon et al. (2024) demonstrates how GEN students can experience feeling vulnerable, unsure, and stressed at times during their nursing education. This tension can create cognitive dissonance for GEN students, as they may feel pulled between the demands of efficiency and the desire to offer relational care. Research by Hobbs et al. (2020) discusses how presence and the act of being present in nursing care are part of professional practice in nursing.

6.7 Recommendations

Based on the research findings and implications for practice, the following recommendations have been made:

6.7.1 Recommendations for Practice

1. Students need to be placed in clinical practice environments that can actively support relational engagement and recognise that empathy is a way of being-with patients rather than a measurable task or competency.

2. RN preceptors and CEs should be resourced to act as role models of empathetic practice, to strengthen mentorship. This may mean reducing patient loads when RNs supervise students, but it will allow for meaningful engagement and the development of empathy.

3. RNs and CEs need to create safe spaces where students can debrief, share their developing values, and reflect on clinical encounters to help them develop their own values-driven, empathetic practice.

4. Nurses who are positioned in leadership and mentoring roles should be mindful to demonstrate small and meaningful relational practices so students can observe and embody empathy in their practice. Examples of these practices are presence, active listening and relational interactions with others.

5. Students need to be in optimal positions to foster cultural responsiveness with patients and their whānau (family) to recognise this as part of empathetic care. Students need to be in a position where they see role modelling of practices that uphold cultural values such as whakawhanaungatanga (the process of building relationships), aroha (compassion and empathy), and manaakitanga (kindness and hospitality).

6.7.2 Recommendations for Education

1. In educational settings, there needs to move to reframe empathy as a relational, evolving capacity rather than a discrete skill to be measured, or a competency to be met.

2. Students require regular time to reflect on their clinical practice. This needs to be embedded into curricula to enable students to process their experiences and connect them to their professional identity and values.

3. Students need to see examples of empathy through role-modelling in their clinical tutors and CEs. Therefore, CEs need to receive training and be supported to ensure they demonstrate empathetic practice, allowing students to learn from them.

6.7.3 Recommendations for Future Research

1. There is a need for longitudinal studies to explore the development of empathy in GEN students through nursing education and into their first year of practice. The idea is to examine how empathy evolves during the transition from student

to RN as this could further influence recommendations for nursing education and practice.

2. There is a need for comparative studies. Specifically, a study comparing the development of empathy in GEN students and undergraduate nursing students is recommended to inform the findings. This may change recommendations for nursing education and practice, as there may be distinct learning needs and curricular approaches that would be best tailored to support the development of empathy between the two groups.

3. A further recommendation is to conduct a mixed-methods study that combines qualitative and quantitative data. The idea behind this is to explore both the lived experiences of GEN students and measurable outcomes of empathy cultivation in GEN student education, as this study did not seek to explore outcomes of empathy development. Rather, this study relied on the existing literature to describe the outcomes of empathy in healthcare settings.

4. There is a need for future research to explore different cultural perspectives of GEN students and empathy to examine how cultural norms and values influence GEN students' understanding and enactment of empathy. Within the context of Aotearoa New Zealand, specific attention to Māori and Pasifika GEN students would be highly appropriate.

5. The final recommendation is for future research to consider stakeholders and the perspectives of patients, whānau, and healthcare staff. This research would contribute to a deeper understanding of how empathy is perceived, enacted, and developed across various contexts within healthcare.

6.8 Conclusion

This study set out to explore how second-year Graduate Entry Nursing (GEN) students in Aotearoa New Zealand experience the development of empathy in clinical practice. This study, to my knowledge, is the first to explore the phenomenon of empathy development in GEN students. It is therefore significant and offers a nuanced understanding of the lived experience of how empathy is developed in a unique group of nursing students. The aim of the study was to explore and answer the question: "**How**

do GEN nursing students in Aotearoa New Zealand experience the development of empathy in clinical practice?" Hermeneutic phenomenology was selected as the research methodology due to its appropriateness in seeking to understand how an experience is interpreted through stories and narratives. My role in this research was to conduct the research and answer the research question. I interpreted the GEN students' narratives to make-meaning from the best of my research abilities. GEN student volunteers were invited to participate in the study on a first-come, first-served basis. Those eligible to participate in the study were then interviewed in a one-on-one setting via Microsoft Teams. The interviews were recorded and then transcribed for analysis. The data was thematically analysed using van Manen's six-step method. Three themes emerged from the data, as follows: being-present, being-with, and transforming.

Being-present was the theme that could describe empathy as an embodied act that emerged through the quality of presence. Being-present involved attunement to the patient's world and a response to their needs. The next theme, being-with reflected the quiet, attentive, and relational ways in which GEN students experienced connection with others. Being-with, in this way, was interpreted as the way one can relate to the feelings and emotions of others through shared humanity, and the ability to bridge connection, even in situations where they lived experience of other feels unfamiliar. The final theme was transforming, which could be interpreted as how the GEN students experienced developing empathy through coming to understand the importance of relational presence, questioning practice, and observing others. Transforming occurred in environments where students could grow. Grow and change their practice to become empathetic professionals who embody empathy.

This study explains that empathy cannot be taught through theoretical instruction. Empathy, and its development in GEN students, is cultivated through meaningful interactions, self-awareness, and the willingness to engage relationally with others. Empathy is a disposition that is developed through experiencing and resonating with the underlying feelings, moods and emotions of others. It is a way of being that is developed by leaning into the discomfort of silence, by slowing down, pausing, mindfully observing the subtle gestures, and attuning into the inner world of others. Empathy requires the metaphorical key to connection. The key to a co-created space between the giver and the receiver that turns the lock to another's lived experience.

Throughout this thesis, the voices of GEN students have illustrated the complex and ever-evolving nature of developing empathy. They explain that it involves walking alongside another person, down their path, on their journey. It is walking with someone and saying, sometimes without needing to speak the words: “I am unfamiliar with this path, but I am here. I understand. I am here with you through this path you walk.” Importantly, the GEN students explicitly expressed maintaining a professional boundary between themselves and the patient and or their whānau (family). The GEN students are not walking in the same shoes as their patients or their whānau (family) or taking them off to try on. They are saying, “I will walk with you?” “I will walk with you, down this path, to begin to understand what this experience feels like, and bridge the gap of indifference.” However, it takes time to develop and is an ongoing, cyclical process, embedded in time spent working with others, reflecting on practice, and attuning to ways of being that unfold in real-world settings (Jeffrey, 2016). Students experience the development of empathy through doing, trying, observing, thinking, conversing, and reflecting on the clinical experience that they have been involved with and have observed in practice.

Clinical practice and nursing education must provide environments that foster the development of empathy. Students need to be given space to connect, communicate, and truly be with patients. For empathy to flourish, GEN students must be given time in clinical practice settings and time to dwell on experiences. As empathy is a fundamental graduate nursing attribute, this study is important for stakeholders, such as tertiary institutes, clinical placement setting providers, and policy developers, as it offers insights into how these students develop this fundamental attribute. Students need time at the bedside to build relationships with patients, observe professional role models in action, and reflect on positive and challenging encounters they witness.

6.9 Summary

This chapter has discussed the findings of this study by drawing on the three themes that emerged from the students’ experiences from clinical placement: *being-present, being-with, and transforming.* This chapter explored the phenomenological insights from the findings and compared these themes with wider literature. Implications for nursing education and clinical practice have been identified under each theme as it was

discussed. The strengths and weaknesses of this study have been identified, and recommendations for practice, education and future research have been discussed. Finally, I provided a conclusion of the study. Below are my closing thoughts. My final reflection.

6.10 Reflection Point

As I reflect on this journey, I recognise how my understanding of empathy has evolved. What struck me most throughout this study was the depth and honesty of the participants' insights. In sharing their stories, they brought the research question to life in ways that were more nuanced, powerful, and moving than I had imagined. Their reflections challenged my assumptions and revealed the many subtleties of how empathy is formed in clinical practice.

I thoroughly enjoyed interviewing the GEN student participants, and this was my favourite part of the research process. There is one moment from the interviews that stays with me. A participant paused at the end of our interview to thank me. They said the research felt important to them and to nursing practice. The student believed that this research was necessary for the future of nursing education. It was an unexpected moment of gratitude. In that moment, I was reminded of why this work matters. It affirmed the value of listening, of creating space for voices, and of doing research that can inform theory and change. This study has deepened my belief in the importance of empathy, not just as a research subject, but as a foundation for how we teach, care, and lead in nursing. Empathy encourages connection, stillness, and harmony. Empathy can really change the world for the better.

> He aha te mea nui o te ao? He tāngata, He tāngata, He tāngata! (What is the most important thing in the world? It is people, it is people, it is people!) (Masters-Awatere et al., 2019, p.435).

This Māori whakataukī, or proverb, is one of my favourites as it emphasises the importance of nurses' work. It aligns with my values within the profession – people are the most important thing in the world. More importantly, it aligns with empathetic nursing practice. People are central to nursing care, and their dignity and well-being are cornerstones of nursing practice (Parandeh et al., 2016). Nursing is about the people, and people need to be understood.

At the beginning of this study, I aimed to define empathy by combining existing definitions of empathy from the literature. Using the work of Hojat et al. (2018), Levett-Jones et al. (2019), López-Martínez et al. (2023) and the four antecedents of empathy documented by Wiseman (1996), I defined empathy as: A cognitive attribute that involves understanding the feelings of another's experience and seeing the world as others see it, through non-judgmental eyes, and the ability to communicate this understanding back to the other in a space that they find emotionally safe. Based on the findings from this study, I now challenge the existing definitions of empathy that frame it as a primarily cognitive or behavioural skill. This study reveals that empathy emerges through attunement, perceived understanding, and interpretation, as it connects with the inner world and lived experiences of the other. Empathy is not solely a cognitive attribute, but a relational way of being that evolves over time. Empathy unfolds through embodied attunement, interpretive understanding, and perspective taking (Reniers et al., 2022). It emerges in moments of presence and being-with, where one connects with the vulnerabilities, emotions, moods and feelings of another, to foster empathetic care.

References

Agosta, L. (2014). A rumor of empathy: Reconstructing Heidegger's contribution to empathy and empathic clinical practice. *Medicine, Health Care and Philosophy, 17*(2), 281-292. https://doi.org/10.1007/s11019-013-9506-0

Alharahsheh, H. H., & Pius, A. (2020). A review of key paradigms: Positivism VS interpretivism. *Global Academic Journal of Humanities and Social Sciences*, *2*(3), 39–43. https://www.researchgate.net/publication/338244145_A_Review_of_key_paradigms_positivism_VS_interpretivism

Allen, L. M., Cooper, S. J., & Missen, K. (2022). Bachelor of science in nursing students' perceptions of being a nurse: A scoping review. *Journal of Professional Nursing, 42*, 281–289. https://doi.org/10.1016/j.profnurs.2022.07.021

Alligood, M. (2005). Rethinking empathy in nursing education: Shifting to a developmental view. *Annual Review of Nursing Education, 3*(17), 299-309. https://www.researchgate.net/publication/315498540_Rethinking_Empathy_in_Nursing_Education_Shifting_to_a_Developmental_View

Almutairi, M., Simpson, A., Khan, E., & Dickinson, T. (2022). The value of social media use in improving nursing students' engagement: A systematic review. *Nurse Education in Practice*, *64*, Article 103455. https://doi.org/10.1016/j.nepr.2022.103455

Alsalamah, Y., Albagawi, B., Babkair, L., Alsalamah, F., Itani, M. S., Tassi, A., & Fawaz, M. (2022). Perspectives of nursing students on promoting reflection in the clinical setting: A qualitative study. *Nursing Reports, 12*(3), 545–555. https://doi.org/10.3390/nursrep12030053

Alsaigh, R., & Coyne, I. (2021). Doing a hermeneutic phenomenology research underpinned by Gadamer's philosophy: A framework to facilitate data analysis. *International Journal of Qualitative Methods*, *20*. https://doi.org/10.1177/16094069211047820

Al-amer, R. M., Weldat, K. A., Ali, A., Darwish, M., Bashtawy, M. A., Mosleh, S. M., & Randall, S. (2022). Arab nursing students' perception of the emotional experience of patient care: A phenomenological study. *Nursing Forum*, *57*(6), 1176–1183. https://doi.org/10.1111/nuf.12818

Angelou, M. (n.d.). *I've learned that people will forget what you said…* [Quote]. Goodreads. Retrieved [July 28, 2025], from https://www.goodreads.com/quotes/5934-i-ve-learned-that-people-will-forget-what-you-said-people

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Arman, M. (2023). Empathy, sympathy, and altruism - An evident triad based on compassion. A theoretical model for caring. *Scandinavian Journal of Caring Sciences*, *37*(3), 862–871. https://doi.org/10.1111/scs.13163

Arribas-Ayllon, M. A. M. (2023). Caring through things at a distance: Intimacy and presence in teletherapy assemblages. *Sociology of Health & Illness*, *46*(1), 3–18. https://doi.org/10.1111/1467-9566.13685

Aryuwat, P., Holmgren, J., Asp, M., Radabutr, M., & Lövenmark, A. (2024). Experiences of nursing students regarding challenges and support for resilience during clinical education: A qualitative study. *Nursing Reports*, *14*(3), 1604–1620. https://doi.org/10.3390/nursrep14030120

Aryuwat, P., Asp, M., Lövenmark, A., Radabutr, M., & Holmgren, J. (2023). An integrative review of resilience among nursing students in the context of nursing education. *Nursing Open, 10*(5), 2793–2818. https://doi.org/10.1002/nop2.1559

Aubeeluck, A., Stacey, G., & Stupple, E. J. (2016). Do graduate entry nursing students experience ‘imposter phenomenon’?: An issue for debate. *Nurse Education in Practice, 19*, 104–106. https://doi.org/10.1016/j.nepr.2016.06.003

Auckland University of Technology. (n.d.-a). *Master of Nursing Science.* Auckland University of Technology. https://www.aut.ac.nz/study/study-options/health-sciences/courses/master-of-nursing-science

Auckland University of Technology. (n.d.-b). *Te Aranui: AUT Te Tiriti Framework.* Auckland University of Technology. https://www.aut.ac.nz/__data/assets/pdf_file/0008/802925/Te-Aronui-v8.pdf

Azadian, M., Nasrabadi, T., Ebadi, A., & Nouri, J. M. (2024). Role model nursing instructors and facilitation of students' professional growth process: Directed content analysis. *Iranian Journal of Nursing and Midwifery Research*, *29*(2), 208–216. https://doi.org/10.4103/ijnmr.ijnmr_334_22

Babaii, A., Mohammadi, E., & Sadooghiasl, A. (2021). The meaning of the empathetic nurse-patient communication: A qualitative study. *Journal of Patient Experience*, *8*, 1–9. https://doi.org/10.1177/23743735211056432

Baldwin, A., Mills, A., Birks, M., & Budden, L. (2014). Role modelling in undergraduate nursing education: An integrative literature review. *Nurse Education Today, 34(*6), 18–26. https://doi.org/10.1016/j.nedt.2013.12.007

Barchard F. (2022). Exploring the role of reflection in nurse education and practice. *Nursing Standard, 37*(6), 45–49. https://doi.org/10.7748/ns.2022.e11605

Bastami, M., Imani, B., & Koosha, M. (2022). Operating room nurses' experience about patient cares for laparotomy surgeries: A phenomenological study. *Journal of Family Medicine and Primary Care*, *11*(4), 1282–1287. https://doi.org/10.4103/jfmpc.jfmpc_1085_21

Beauvais, A., Andreychik, M., & Henkel, L. (2017). The role of emotional intelligence and empathy in compassionate nursing care. *Mindfulness & Compassion, 2*(2), 92–100. https://doi.10.1016/j.mincom.2017.09.001

Beck, C. (2021). Max van Manen's hermeneutic phenomenological approach. In *Max van Manen's hermeneutic phenomenological approach*. SAGE Publications, 0, 73–82. https://doi.org/10.4135/9781071909669.n13

Becker, C. (2003). Art and science of midwifery. *Journal of Midwifery & Women's Health, 48*(1), 82–88. https://doi.org/10.1016/S1526-9523(02)00413-0

Benner, P. (1984). *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Addison-Wesley.

Benner, P. E., Sutphen, M., Leonard, V. & Day, L. (2010). *Educating nurses: A call for radical transformation.* San Francisco, CA: Jossey-Bass.

Benner, P., & Tanner, C. (1987). Clinical judgment: How expert nurses use intuition. *The American Journal of Nursing, 87*(1), 23. https://doi.org/10.2307/3470396

Betti, A., Biderbost, P., & Domonte, A. G. (2022). Can active learning techniques simultaneously develop students' hard and soft skills? Evidence from an international relations class. *PloS one*, *17*(4), e0265408. https://doi.org/10.1371/journal.pone.0265408

Bowie, B. H., & Carr, K. C. (2013). From coach to colleague: adjusting pedagogical approaches and attitudes in accelerated nursing programs. *Journal of Professional Nursing,* 29, 395–401. https://doi.org/10.1016/j.profnurs.2012.05.016

Brown, B. (2021). *Atlas of the heart: Mapping meaningful connection and the language of human experience.* First edition. New York, Random House.

Brown, B. (2018). *Dare to lead: Brave work, tough conversations, whole hearts.* New York, Random House.

Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead.* New York, NY, Gotham Books.

Brunero, S., Cowan, D., Chaniang, S., & Lamont, S. (2022). Empathy education in post graduate nurses: An integrative review. *Nurse Education Today*, *112*, Article 105338. https://doi.org/10.1016/j.nedt.2022.105338

Bryne, M., Campos, C. F., Daly, S., Lok, B. & Miles, A. (2023). The current state of empathy, compassion and person-centred communication training in

healthcare: An umbrella review. *Patient Education and Counselling. 119,* Article 108063. https://doi.org/10.1016/j.pec.2023.108063

Budler, L. C., Gosak, L., Vrbnjak, D., Pajnkihar, M., & Štiglic, G. (2022). Emotional intelligence among nursing students: Findings from a longitudinal study. *Healthcare, 10*(10), Article 2032. https://doi.org/10.3390/healthcare10102032

Burgess, S., Rogers, M. & Jefferies, D. (2022). Empathy and narrative: A discussion of contemporary stories from childcare and healthcare. *International Electronic Journal of Elementary Education. 14,* (5), 631–646. https://doi.org/10.26822/iejee.2022.268

Cao, X., Wang, L., Wei, S., Li, J. & Gong, S. (2021). Prevalence and predictors for compassion fatigue and compassion satisfaction in nursing students during clinical placement, *Nurse Education in Practice, 51*, Article 102999, https://doi.org/10.1016/j.nepr.2021.102999

Cavanagh, N., Cockett, G., Heinrich, C., Doig, L., Fiest, K., Guichon, J. R., Page, S., Mitchell, I., & Doig, C. J. (2020). Compassion fatigue in healthcare providers: A systematic review and meta-analysis. *Nursing Ethics*, *27*(3), 639–665. https://doi.org/10.1177/0969733019889400

Chang Q. (2022). The contribution of a hermeneutic approach to investigate psychological variables in second language acquisition. *Frontiers in Psychology*, *13*, Article 1055249. https://doi.org/10.3389/fpsyg.2022.1055249

Cilar, L., Spevan, M., Čuček Trifkovič, K., & Štiglic, G. (2020). What motivates students to enter nursing? Findings from a cross-sectional study. *Nurse Education Today*, *90*, Article 104463. https://doi.org/10.1016/j.nedt.2020.104463

Chödrön, P. (2001). *The places that scare you: A guide to fearlessness in difficult times*. Shambhala Publications.

Coate, M. (2023). On Heidegger's conception of emotion, which is to say, Husserl's conception of time: an analysis of *Befindlichkeit* and temporality. *Continual Philosophy Review, 56*, 549–576. https://doi.org/10.1007/s11007-023-09611-

Cooper, C., Booth, A., Varley-Campbell, J., Britten. N & Garside. R. (2018). Defining the process to literature searching in systematic reviews: A literature review of guidance and supporting studies. *BMC Medical Research Methodology, 18*, Article 85. https://doi.org/10.1186/s12874-018-0545-3

Costa, D. S. J., Mercieca-Bebber, R., Tesson, S., Seidler, Z., & Lopez, A. L. (2019). Patient, client, consumer, survivor or other alternatives? A scoping review of preferred terms for labelling individuals who access healthcare across settings. *BMJ open*, *9*(3), e025166. https://doi.org/10.1136/bmjopen-2018-025166

Creswell, J. W. (2021). *A Concise Introduction to Mixed Methods Research.* Thousand Oaks, CA: Sage.

Crotty. M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Sydney, Australia: Allen & Unwin.

Decety, J., & Cowell, J. M. (2015). Empathy, justice, and moral behavior. *AJOB Neuroscience*, *6*(3), 3–14. https://doi.org/10.1080/21507740.2015.1047055

Denzin, N. K., & Lincoln, Y. S. (2013). *Paradigms and perspectives in contention*. In N. K. Denzin & Y. S. Lincoln (Eds.), The landscape of qualitative research (4th ed., pp. 189-198). Sage.

Dewar, J., Cook, C., Smythe, E., & Spence, D. (2023). A Heideggerian analysis of good care in an acute hospital setting: Insights from healthcare workers, patients and families. *Nursing Inquiry, 30(4), e12561.* https://doi.org/10.1111/nin.12561

Dibley, L., Dickerson, S., Duffy, M., & Vandermause, R. (2020a). *Being ethical.* In Doing Hermeneutic Phenomenological Research: A Practical Guide (pp. 67-90). SAGE Publications Ltd, https://doi.org/10.4135/9781529799583

Dibley, L., Dickerson, S., Duffy, M., & Vandermause, R. (2020b). Data analysis and interpretation. In Doing Hermeneutic Phenomenological Research: A Practical Guide (pp. 113-134). SAGE Publications Ltd, https://doi.org/10.4135/9781529799583

Dodgson, J. E. (2023). Phenomenology: Researching the lived experience. *Journal of Human Lactation*, *39*(3), 385–396. https://doi.org/10.1177/08903344231176453

Dossey D.M., & Keegen L. (2016). *Holistic nursing. A handbook for practice, 7th edn.,* Jones & Bartlett Learning, Burlington, NJ.

Downey, K. M., & Asselin, M. E. (2015). Accelerated master's programs in nursing for non-nurses: An integrative review of students' and faculty's perceptions. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing*, *31*(3), 215–225. https://doi.org/10.1016/j.profnurs.2014.10.002

Du, J., Huang, S., Lu, Q., Ma, L., Lai, K. & Li, K. (2022). Influence of empathy and professional values on ethical decision-making of emergency nurses: A cross-sectional study, *International Emergency Nursing, 63*, Article 101186. https://doi.org/10.1016/j.ienj.2022.101186

Eklund, H. J., Holmström, I. K., Ollén, A. L., Sundler, A. J., Hochwälder, J., & Hammar, L. M. (2019). Empathy levels among nursing students: A comparative cross-sectional study. *Nursing Open, 6*(3), 983–989. https://doi.org/10.1002/nop2.280

El Atmani, Z. (2025). Exploring the development of reflective practice knowledge in nursing students. *Journal of Research in Environmental and Science Education, 2*(1), 29–37. https://doi.org/10.70232/jrese.v2i1.8

Elder, H. (2020). *Aroha: Māori wisdom for a contented life lived with harmony with our planet.* Penguin.

Elwood, S., & Martin, D. (2000). “Placing” interviews: location and scales of power in qualitative research, *Professional Geographer, 52*(4), 649-657. https://doi.org/10.1111/0033-0124.00253

Engward, H., Goldspink, S., Iancu, M., Kersey, T., & Wood, A. (2022). Togetherness in separation: Practical considerations for doing remote qualitative interviews

ethically. *International Journal of Qualitative Methods*, *21*. https://doi.org/10.1177/16094069211073212

Ernawati, & Bratajaya, C. N. A. (2021). Senior nurses' perceptions of essential soft skills for novice nurses in a private hospital in Jakarta, Indonesia: A phenomenological study. *Belitung Nursing Journal*, *7*(4), 320–328. https://doi.org/10.33546/bnj.1549

Flarity, K., Gentry, J. E., & Mesnikoff, N. (2013). The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses. *Advanced Emergency Nursing Journal, 35*(3), 247–258. https://doi.org/10.1097/TME.0b013e31829b726f

Frechette, J., Bitzas, V., Aubry, M., Kilpatrick, K., & Lavoie-Tremblay, M. (2020). Capturing lived experience: Methodological considerations for interpretive phenomenological inquiry. *International Journal of Qualitative Methods*, *19*(2), Article 160940692090725. https://doi.org/10.1177/1609406920907254

Gadamer, H. G. (2004). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans.). Bloomsbury Publishing.

Ghazwani, S., Alshowkan, A. & AlSalah, N. (2023). A study of empathy levels among nursing interns: A cross-sectional study. *BMC Nursing, 22*, 226. https://doi.org/10.1186/s12912-023-01381-y

Gidman J. (2013). Listening to stories: Valuing knowledge from patient experience. *Nurse Education in Practice*, *13*(3), 192–196. https://doi.org/10.1016/j.nepr.2012.09.006

Gill, M. J. (2014). The possibilities of phenomenology for organizational research. *Organizational Research Methods, 17*(2), 118-137. https://doi.org/10.1177/1094428113518348

Girotti, M., Bulin, S. E., & Carreno, F. R. (2024). Effects of chronic stress on cognitive function - From neurobiology to intervention. *Neurobiology of Stress*, *33*, Article 100670. https://doi.org/10.1016/j.ynstr.2024.100670

Giroux, C. M., & Moreau, K. A. (2022). Nursing students' use of social media in their learning: A case study of a Canadian school of nursing. *BMC Nursing*, *21*(1), Article 195. https://doi.org/10.1186/s12912-022-00977-0

Grant, B., & Giddings, L. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse,* 13, 10–28. https://doi.org/10.5172/conu.13.1.10

Guidi, C., & Traversa, C. (2021). Empathy in patient care: from 'clinical empathy' to 'empathic concern'. *Medicine, Health Care, and Philosophy*, *24*(4), 573–585. https://doi.org/10.1007/s11019-021-10033-4

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and “ethically important moments” in research. *Qualitative Inquiry, 10*(2), 261–280. https://doi.org/10.1177/1077800403262360

Habib, H., Niinuma, S. A., Alrefaie, K., Al Khalaf, H. A., Hani, M. J., Al-Rawi, Z. Y. M., Hussain, Z., Menezes, P., Roy, S. R., Mathew, B., Guraya, S. Y., Nicholson, A., & Guraya, S. S. (2025). Shades of acceptance and adjustment: A discursive psychological analysis to showcase empathy in medical students. *BMC Medical Education*, *25*(1), Article 415. https://doi.org/10.1186/s12909-024-06625-2

Hajibabaee, F., A Farahani, M., Ameri, Z., Salehi, T., & Hosseini, F. (2018). The relationship between empathy and emotional intelligence among Iranian nursing students. *International Journal of Medical Education*, *9*, 239–243. https://doi.org/10.5116/ijme.5b83.e2a5

Halpern J. (2014). From idealized clinical empathy to empathic communication in medical care. *Medicine, Health care, and Philosophy*, *17*(2), 301–311. https://doi.org/10.1007/s11019-013-9510-4

Halpern J. (2003). What is clinical empathy?. *Journal of General Internal Medicine*, *18*(8), 670–674. https://doi.org/10.1046/j.1525-1497.2003.21017.x

Harman, G. (2007). *Heidegger explained: From phenomenon to thing.* Open Court.

Harper, D. (2025). Hermeneutic*, Online Etymology Dictionary* https://www.etymonline.com/word/hermeneutic

Harper, D. (2024). Empathy. *Online Etymology Dictionary.* https://www.etymonline.com/search?q=empathy&type=0

Hayes, A. M., Laurenceau, J. P., Feldman, G., Strauss, J. L., & Cardaciotto, L. (2007). Change is not always linear: the study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review*, *27*(6), 715–723. https://doi.org/10.1016/j.cpr.2007.01.008

Hays M. M. (2013). A weekend and a lifetime: A linkage to empathy. *Holistic Nursing Practice*, *27*(5), 282–283. https://doi.org/10.1097/HNP.0b013e31829b92ab

Health Practitioners Competence Assurance Act 2003. (n.d). No. 48. Ministry of Health. New Zealand. https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203320.html

Hedger, N., Haffey, A., McSorley, E., & Chakrabarti, B. (2018). Empathy modulates the temporal structure of social attention. *Proceedings. Biological Sciences*, *285*(1893), Article 20181716. https://doi.org/10.1098/rspb.2018.1716

Hegge, M., & Larson, V. (2008). Stressors and coping strategies of students in accelerated baccalaureate nursing programs. *Nurse Educator*, *33*(1), 26–30. https://doi.org/10.1097/01.NNE.0000299492.92624.95

Heggestad, A. K. T., Konow-Lund, A. S., Christiansen, B., & Nortvedt, P. (2022). A vulnerable journey towards professional empathy and moral courage. *Nursing Ethics*, *29*(4), 927–937. https://doi.org/10.1177/09697330221074013

Heidegger, M. (1977). *The question concerning technology and other essays* (W. Lovitt, Trans.). Harper & Row.

Heidegger, M. (1962). Being and Time (J. Macquarrie, & E. Robinson, Trans.). Oxford, UK & Cambridge, USA: Blackwell Publishers Ltd.

Hobbs, P. S., du Plessis, E., & Benadé, P. (2020). Here and now: Lived experiences of professional nurses practising caring presence in a rural public hospital in the

North West Province, South Africa. *Journal of Interdisciplinary Health Services, 25*, Article 1405. https://doi.org/10.4102/hsag.v25i0.1405

Hojat, M., DeSantis, J., Shannon, S. C., Mortensen, L. H., Speicher, M. R., Bragan, L., LaNoue, M., & Calabrese, L. H. (2018). The Jefferson scale of empathy: A nationwide study of measurement properties, underlying components, latent variable structure, and national norms in medical students. *Advances in Health Sciences, Education, Theory and Practice*, *23*(5), 899–920. https://doi.org/10.1007/s10459-018-9839-9

Hoogendoorn, C. J., & Rodríguez, N. D. (2023). Rethinking dehumanization, empathy, and burnout in healthcare context. *Current Opinion in Behavioral Sciences*, *52*, Article 101285. https://doi.org/10.1016/j.cobeha.2023.101285

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the Key Tenets of Heidegger's Philosophy for Interpretive Phenomenological Research. *International Journal of Qualitative Methods*, *15*(1). https://doi.org/10.1177/1609406916680634

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). Te Ara Tika: Guidelines for Māori Research Ethics: A framework for researchers and ethics committee members. *Health Research Council of New Zealand.* https://www.hrc.govt.nz/sites/default/files/2022-06/Te%20Ara%20Tika%20Guidelines.pdf

Hunter, K & Cook, C. (2020). Cultural and clinical practice realities of Māori nurses in Aotearoa New Zealand: The emotional labour of indigenous nurses. *Nursing Praxis in Aotearoa New Zealand, 36*(3), 7–23. https://doi.org/10.36951/27034542.2020.011

Hurley, G., Curtis, K., & Hammond, J. A. (2022). Hermeneutic phenomenological research on how nurse educators make meaning of compassion and understand its role in their professional practice. *Nurse Education Today*, *119*, Article 105588. https://doi.org/10.1016/j.nedt.2022.105588

Jaastad, T. A., Ueland, V., & Koskinen, C. (2022). The meaning of reflection for understanding caring and becoming a caring nurse. *Scandinavian Journal of Caring Sciences*, *36*(4), 1180–1188. https://doi.org/10.1111/scs.13080

Jacobsen, M. H. (2024). *Exploring Emotions in Social Life, 1st Edition*. Routledge.

Jamieson, M. K., Govaart, G.H. & Pownall, M. (2023). Reflexivity in quantitative research: A rationale and beginner's guide. *Social and Personal Psychology Compass, 17*(4), *e12735*. https://doi.org/10.1111/spc3.12735

Jamieson, I., Norris, K., Short, K., Papps, E. & Dixon, A. (2020). Graduate entry to nursing: An exploration of the demographic characteristics of New Zealand students. *Nurse Education in Practice,* 48. Article 102855. https://doi.org/10.1016/j.nepr.2020.102855

Jeffrey D. (2016). The process of empathy: Insights from John Berger's A Fortunate Man. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners*, *66*(650), 476–477. https://doi.org/10.3399/bjgp16X686869

Joober, R., Schmitz, N., Annable, L., & Boksa, P. (2012). Publication bias: What are the challenges, and can they be overcome? *Journal of Psychiatry & Neuroscience*, *37*(3), 149–152. https://doi.org/10.1503/jpn.120065

Kaldal, M. H., Kristiansen, J. & Uhrenfeldt. L. (2018). Nursing students experienced personal inadequacy, vulnerability and transformation during their patient care encounter: A qualitative meta-synthesis. *Nurse Education Today, 64*, 99–107. https://doi.org/10.1016/j.nedt.2018.02.008

Kaur, S., Saini, S. & Waia, I. (2018). Assessment of level of empathy among nursing students during internship. *Indian Journal of Social Psychiatry, 34*(1), 57-61, https://doi.org/10.4103/ijsp.ijsp_5_17

Keenan, B., (2017). Phenomenological approach utilizing semi-structured interviews: Do early career researchers feel they are practicing in an environment that values research? *SAGE Publications*, https://doi.org/10.4135/9781526419026

Keong Yong, Y., Md Husin, M. & Kamarudin, S. (2023). Understanding Research Paradigms: A Scientific Guide. *Journal of Contemporary Issues in Business and Government.* https://doi.org/10.47750/cibg.2021.27.02.588

Keutchafo, E. L. W., Kerr, J., & Baloyi, O. B. (2022). A model for effective nonverbal communication between nurses and older patients: A grounded theory inquiry. *Healthcare*, *10*(11), Article 2119. https://doi.org/10.3390/healthcare10112119

Konow Lund, A., Heggestad, A. K. T., Nortvedt, P., & Christiansen, B. (2018). Developing mature empathy among first-year students: The learning potential of emotional experiences. *Nordic Journal of Nursing Research*, *38*(3), 128–134. https://doi.org/10.1177/2057158517722057

Krist, A. H., Tong, S. T., Aycock, R. A., & Longo, D. R. (2017). Engaging Patients in Decision-Making and Behavior Change to Promote Prevention. *Studies in Health Technology and Informatics*, *240*, 284–302. https://pubmed.ncbi.nlm.nih.gov/28972524/

Kurt, Y., Turhal, E., & Batmaz, F. (2023). Nursing students' processes of taking role models and being role models: A descriptive phenomenological study. *Nurse Education Today*, *132*, 106015. https://doi.org/10.1016/j.nedt.2023.106015

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. *BMC Nursing*, *20*(1), Article 158. https://doi.org/10.1186/s12912-021-00684-2

Laari, L., Anim-Boamah, O, & Boso, C. (2021). Integrative review of soft skills the desirable traits and skills in nursing practise. *Research Square,* 1–19. https://doi.org/10.21203/rs.3.rs-605637/v1

Lammi, W. (1991). Hans-Georg Gadamer's "Correction" of Heidegger. *Journal of the History of Ideas*, *52*(3), 487–507. https://doi.org/10.2307/2710048

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International*

Journal of Qualitative Methods, 2(3), 21–35. https://journals.sagepub.com/doi/pdf/10.1177/160940690300200303

Lee, Y. S., Yun, Y., Kim, E. K., & Kim, H. S. (2023). Relationship between self-consciousness and empathy for cancer patients among nursing students: The moderating effects of clinical practice satisfaction. *Nurse Education Today*, *121*, Article 105715. https://doi.org/10.1016/j.nedt.2023.105715

Levett-Jones, T., Cant, R. & Lapkin, S. (2019). A systematic review of the effectiveness of empathy education for undergraduate nursing students. *Nurse Education Today, 75*, 80–94. https://doi.org/10.1016/j.nedt.2019.01.006

Liu, Y., Wang, L., Shao, H., Han, P., Jiang, J., & Duan, X. (2022). Nursing students' experience during their practicum in an intensive care unit: A qualitative meta-synthesis. *Frontiers in Public Health*, *10*, Article 974244. https://doi.org/10.3389/fpubh.2022.974244

López-Martínez, A. E., Serrano-Ibáñez, E. R., Solís-Serrano, L., Ramírez-Maestre, C., & Esteve. R. (2023). Empathy among health science undergraduates toward the diagnosis of chronic pain: An experimental study, *Nurse Education Today, 130,* Article 105922. https://doi.org/10.1016/j.nedt.2023.105922

Lorié, Á., Reinero, D. A., Phillips, M., Zhang, L., & Riess, H. (2017). Culture and nonverbal expressions of empathy in clinical settings: A systematic review. *Patient Education and Counselling*, *100*(3), 411–424. https://doi.org/10.1016/j.pec.2016.09.018

Machost, H., & Stains, M. (2023). Reflective practices in education: A primer for practitioners. *CBE Life Sciences Education, 22*(2). https://doi.org/10.1187/cbe.22-07-0148

Makarem, A., Heshmati-Nabavi, F., Afshar, L., Yazdani, S., Pouresmail, Z., & Hoseinpour, Z. (2019). The comparison of professional confidence in nursing students and clinical nurses: A cross-sectional study. *Iranian Journal of Nursing and Midwifery Research*, *24*(4), 261–267. https://doi.org/10.4103/ijnmr.IJNMR_102_17

Malet, P., Bioy, A., & Santarpia, A. (2022). Clinical perspectives on the notion of presence. *Frontiers in Psychology*, *13*, Article 783417. https://doi.org/10.3389/fpsyg.2022.783417

Matchim, Y., & Kongsuwan, W. (2015). Thai nursing students' experiences when attending real life situations involving cardiac life support: A phenomenological study. *Nurse Education Today*, *35*(12), 1186–1191. https://doi.org/10.1016/j.nedt.2015.05.010

Masters-Awatere, B., Rarere, M., Gilbert, R., Manuel, C., Scott, N. (2019). He aha te mea nui o te ao? He tāngata! (What is the most important thing in the world? It is people!). *Australian Journal of Primary Health, 25*(5), 435–442. https://doi.org/10.1071/PY19027

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *BMJ, 320*(7228), 50–52. https://doi.org/10.1136/bmj.320.7226.50

McConnell, S., Ozawa-de Silva, B.R., & Ozawa-de Silva, C. (2024). Cultivating empathy and compassion: Lived experiences of engagement with cognitively-based compassion training in the US. *Ethos, 52*(2), 206–224. https://doi.org/10.1111/etho.12424

McDaniel, S. H., Morse, D. S., Edwardsen, E. A., Taupin, A., Gurnsey, M. G., Griggs, J. J., Shields, C. G., & Reis, S. (2021). Empathy and boundary turbulence in cancer communication. *Patient Education and Counseling*, *104*(12), 2944–2951. https://doi.org/10.1016/j.pec.2021.04.002

Macdiarmid, R., McClunie-Trust, P., Shannon, K., Winnington, R., Donaldson, A. E., Jarden, R. J., et al. (2021a). What motivates people to start a graduate entry nursing programme: an interpretive multi-centred case study. *SAGE Open Nursing,* 7, Article 23779608211011310. https://doi.org/10.1177/23779608211011310

Macdiarmid, R., Turner, R., Winnington, R., McClunie-Trust, P., Donaldson, A., Shannon, K., et al. (2021b). What motivates people to commence a graduate

entry nursing programme: A mixed-method scoping review. *BMC Nursing, 20*, Article 12. https:// doi.org/10.1186/s12912-021-00564-9

McHugh, M. D., & Lake, E. T. (2010). Understanding clinical expertise: Nurse education, experience, and the hospital context. *Research in Nursing & Health*, *33*(4), 276–287. https://doi.org/10.1002/nur.20388

Midwifery Council of New Zealand. (n.d). *Becoming a Midwife.* Available from: https://midwiferycouncil.health.nz/Public/Public/07.-I-want-to-be-a-midwife-Aotearoa--New-Zealand/Becoming-a-Midwife.aspx?hkey=81d4cc8c-cf8d-4000-a437-c6b87e1eb068

Ministry of Health (2024). *Studying Nursing.* https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/studying nursing#:~:text=To%20become%20a%20registered%20nurse,institute%20of%20technology%20or%20university

Moropa, T. D., Matshaka, L., & Makhene, A. (2025). Enhancing effective interpersonal interactions through soft skills: perceptions of nurse educators. *BMC Nursing*, *24*(1), 380. https://doi.org/10.1186/s12912-025-02864-w

Moorfield, J. C. (n.d.-a). Karakia. *In Te Aka Māori Dictionary.* https://maoridictionary.co.nz/search?&keywords=karakia#:~:text=1.,%2C%20recite%20a%20prayer%2C%20chant

Moorfield, J. C. (n.d.-b). Mana whenua*. In Te Aka Māori Dictionary.* https://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=mana+whenua

Moorfield, J. C. (n.d.-c). Tamariki*. In Te Aka Māori Dictionary.* https://maoridictionary.co.nz/search?keywords=tamariki

Moorfield, J. C. (n.d.-d). Whaiora. *In Te Aka Māori Dictionary.* https://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=Whaiora

Moudatsou, M., Stavropoulou, A., Philalithis, A., & Koukouli, S. (2020). The role of empathy in health and social care professionals. *Healthcare, 8*(1), 26. https://doi.org/10.3390/healthcare8010026

Mühlhoff, R., & Willem, T. (2022). Social media advertising for clinical studies: Ethical and data protection implications of online targeting. *Big Data & Society*, *10*(1). https://doi.org/10.1177/20539517231156127

Muindi, F. J., Ramachandran, L. & Tsai, J. W. (2020). Human narratives in science: The power of storytelling. *Trends in Molecular Medicine, 26*(3), 249–251. https://doi.org/10.1016/j.molmed.2019.12.001

Mukhalalati, B. A., & Taylor, A. (2019). Adult learning theories in context: A quick guide for healthcare professional educators. *Journal of Medical Education and Curricular Development*, *6*. https://doi.org/10.1177/2382120519840332

Neill M. (2012). Graduate-entry nursing students' journeys to registered nursing. *Nurse Education in Practice*, *12*(2), 89–94. https://doi.org/10.1016/j.nepr.2011.08.002

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education*, *8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

New Zealand Government. (1994). *Health and Disability Commissioner Act 1994*. https://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html

New Zealand Nurses Organisation. (2011). *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice.* New Zealand Nurses Organisation. https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

New Zealand Nurses Organisation. (n.d). *Guideline: Code of Ethics, 2019.* New Zealand Nurses Organisation. https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Code%20of%20Ethics%202019.pdf?ver=19LQpYx8wspprjbTNt9pWw%3d%3d

Nigar, N., & Kostogriz, A. (2025). Unravelling professional identity through lived experiences over time: Employing hermeneutic phenomenology and narrative inquiry. *SAGE Open*, *15*(3). https://doi.org/10.1177/21582440251344922

Nigar, N. (2020). Hermeneutic phenomenology narrative enquiry: A qualitative study design. *Theory and Practice in Language Studies. 10*(1), 10–18. http://dx.doi.org/10.17507/tpls.1001.02

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16,* Article 1609406917733847. https://doi.org/10.1177/1609406917733847

Nursing Council of New Zealand. (2025 February). *Standards of competence of registered nurses*. https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/Nursing/Registered%20nurse/NCNZ031-Competencies-RN-11.pdf

Nursing Council of New Zealand. (2024). *How to become a nurse.* https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/How_to_become_a_nurse.aspx?hkey=de5efbe7-eca4-4d52-ba87-f155f655784f

Nursing Council of New Zealand. (2023 January). *Appendix 8: Requirements for registration as a registered nurse: Information for Students.* https://nursingcouncil.org.nz/Public/NCNZ/Education-section/State_final_examinations.aspx?hkey=f0f3aef9-c9f4-4aea-9abe-0cd9b3b1281c

Nursing Council of New Zealand. (2022). *Clinical Hours Consultation 2022.* https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Consultation/Clinical_Hours_Consultation_2022.aspx

Nursing Council of New Zealand. (n.d.-a). *About us.* https://nursingcouncil.org.nz/Public/NCNZ/About-Us.aspx

Nursing Council of New Zealand. (n.d.-b). *Code of Conduct.* https://nursingcouncil.org.nz/Public/NCNZ/nursing-section/Code_of_Conduct.aspx

Nursing Council of New Zealand. (n.d.-c). *Te Tiriti o Waitangi.* https://nursingcouncil.org.nz/Public/NCNZ/About-section/Te_Tiriti_o_Waitangi.aspx

Oben P. (2020). Understanding the patient experience: A conceptual framework. *Journal of Patient Experience*, *7*(6), 906–910. https://doi.org/10.1177/2374373520951672

Oliveira, M., Dendasck, C. & de Oliveira, E. (2017). The art and science of nursing. *Multidisciplinary Scientific Journal, 4(11),* 18–23. https://doi.org/10.32749/nucleodoconhecimento.com.br/health/the-art-and-science-of-nursing

Ortiz, J. (2016). New graduate nurses' experiences about lack of professional confidence. *Nurse Education in Practice, 19*. 19–24. https://doi.org/10.1016/j.nepr.2016.04.001

Otago University. (n.d). *Master of Nursing Science.* Otago University. https://www.otago.ac.nz/courses/qualifications/mnsc

Oxford University Press. (2024). Empathy. *Oxford Learners Dictionaries.* https://www.oxfordlearnersdictionaries.com/definition/english/empathy#:~:text=%2F%CB%88emp%C9%99%CE%B8i%2F-,%2F%CB%88emp%C9%99%CE%B8i%2F,empathy%20for%20other%20people's%20situations

Oewel, B., Arean, P., & Agapie, E. (2024). Approaches to tailoring between-session mental health therapy activities. *Proceedings of the SIGCHI Conference on Human Factors in Computing Systems,* 1–19. https://doi.org/10.1145/3613904.3642856

O'Mara, L., McDonald, J., Gillespie, M., Brown, H., & Miles, L. (2014). Challenging clinical learning environments: Experiences of undergraduate nursing students.

Nurse Education in Practice, *14*(2), 208–213. https://doi.org/10.1016/j.nepr.2013.08.012

Owen, M. I., & Pfeiffer, K. M. (2023). Mental health characteristics of traditional and accelerated baccalaureate prelicensure nursing students. *The Journal of Nursing Education*, *62*(2), 105–108. https://doi.org/10.3928/01484834-20221213-07

Pannucci, C. J., & Wilkins, E. G. (2010). Identifying and avoiding bias in research. *Plastic and Reconstructive Surgery*, *126*(2), 619–625. https://doi.org/10.1097/PRS.0b013e3181de24bc

Parandeh, A., Khaghanizade, M., Mohammadi, E., & Mokhtari-Nouri, J. (2016). Nurses' human dignity in education and practice: An integrated literature review. *Iranian Journal of Nursing and Midwifery Research*, *21*(1), 1–8. https://doi.org/10.4103/1735-9066.174750

Paré, G., & Kitsiou, S. (2017). Chapter 9: Methods for Literature Reviews. In: Lau F, Kuziemsky C, editors. Handbook of eHealth Evaluation: An Evidence-based Approach [Internet]. Victoria (BC): University of Victoria. Available from: https://www.ncbi.nlm.nih.gov/books/NBK481583/

Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., McInerney, P., Godfrey, C. M., & Khalil, H. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis*, *18*(10), 2119–2126. https://doi.org/10.11124/JBIES-20-00167

Pitard, J. (2017). A journey to the centre of self: Positioning the researcher in autoethnography. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 18*(3), Article 10. https://doi.org/10.17169/fqs-18.3.2764

Pollock, D., Davies, E. L., Peters, M. D. J., Tricco, A. C., Alexander, L., McInerney, P., Godfrey, C. M., Khalil, H., & Munn, Z. (2021). Undertaking a scoping review: A practical guide for nursing and midwifery students, clinicians, researchers, and academics. *Journal of Advanced Nursing, 77*, 2102–2113. https://doi.org/10.1111/jan.14743

Purabdollah, M., Zamanzadeh, V., Ghahramanian, A., Valizadeh, L., Mousavi, S., & Ghasempour, M. (2024). Competency gap among graduating nursing students: what they have achieved and what is expected of them. *BMC Medical Education*, *24*(1), 546. https://doi.org/10.1186/s12909-024-05532-w

Quinney, L., Dwyer, T., & Chapman, Y. (2018). Tensions in the personal world of the nurse family carer: A phenomenological approach. *Nursing Inquiry*, *25*(1), e12206. https://doi.org/10.1111/nin.12206

Rahman, W. A. W. A. (2017). Transformational leadership and empathy: The impact of quality in the health care services in Kelantan*. International Journal of Economics Business and Management Studies. 4(1),* 50–56. https://doi.org/10.20448/802.41.50.56

Ramsey, C. A. (2016). A brief phenomenology of Dasein. *The Journal of Speculative Philosophy*, *30*(4), 499–514. https://doi.org/10.5325/jspecphil.30.4.0499

Regan, P. (2012). Hans-Georg Gadamer's philosophical hermeneutics: Concepts of reading, understanding and interpretation. *Meta: Research in Hermeneutics, Phenomenology and Practical Philosophy, 4*(2), 286–303. https://www.researchgate.net/publication/273447378_Hans-Georg_Gadamer's_philosophical_hermeneutics_Concepts_of_reading_understanding_and_interpretation

Rehman, A. A., & Alharthi, K. (2016). An introduction to research paradigms. *International Journal of Educational Investigations, 3*(8), 51–59. https://www.researchgate.net/publication/325022648_An_introduction_to_research_paradigms

Reniers, R. L. E. P., Abu-Akel, A., & Seara-Cardoso, A. (2022). Editorial: Cognitive empathy and perspective taking: Understanding the mechanisms of normal and abnormal experiences and abilities. *Frontiers in Psychiatry*, *13*, Article 945258. https://doi.org/10.3389/fpsyt.2022.945258

Riess, H. (2022). Empathy can be taught and learned with evidence-based education. *Emergency Medicine Journal. 39,* 418–419. https://emj.bmj.com/content/39/6/418

Riess H. (2017). The science of empathy. *Journal of Patient Experience*, *4*(2), 74–77. https://doi.org/10.1177/2374373517699267

Riessman, C. K. (2002). Analysis of personal narratives. In J. D. Gubrium & J. A. Holstein (Eds.), Handbook of interview research: Context and method. Thousand Oaks, CA: SAGE Publishing, Inc.

Ringwald, W. R., & Wright, A. G. C. (2021). The affiliative role of empathy in everyday interpersonal interactions. *European Journal of Personality*, *35*(2), 197–211. https://doi.org/10.1002/per.2286

Russo-Netzer, P. (2025). Positive anxiety: Existential authenticity as a pathway to well-being. *The Journal of Positive Psychology*, 823–833. https://doi.org/10.1080/17439760.2025.2498128

Saenz, C., Krahn, T. K., Smith, M. J., Haby, M. M., Carracedo, S., & Reveiz, L. (2024). Advancing collaborative research for health: Why does collaboration matter? *BMJ Global Health.* e014971. https://doi.org/10.1136/bmjgh-2024-014971

Saunders, M., & Lewis, P. (2012). *Doing research in Business & Management: An essential guide to planning your project*. Pearson Education, Canada.

Sanderson, B. & Brewer, M. (2017). What do we know about student resilience in health professional education? A scoping review of the literature. *Nurse Education Today, 58*, 65–71. https://doi.org/10.1016/j.nedt.2017.07.018

Schmid, E., Garrels, V., & Skåland, B. (2024). The continuum of rapport: Ethical tensions in qualitative interviews with vulnerable participants. *Qualitative Research, 24*(5), 1253-1271. https://doi.org/10.1177/14687941231224600

Shaghaghi, A., Bhopal, R. S., & Sheikh, A. (2011). Approaches to recruiting 'hard-to-reach' populations into research: A review of the literature. *Health Promotion Perspectives, 1*(2), 86–94. https://doi.org/10.5681/hpp.2011.009

Shannon, K., McClunie-Trust, P., Macdiarmid, R., Jarden, R., Dewar, J., Turner, R., Winnington, R., Jones, V., & Mowatt, R. (2024). Graduate entry nursing students' well-being and transformation in becoming registered nurses: Phase three of a longitudinal case study. *Collegian*. *31*(2), 77 – 83. https://doi.org/10.1016/j.colegn.2023.12.001

Sharon, D., & Grinberg, K. (2018). Does the level of emotional intelligence affect the degree of success in nursing studies? *Nurse Education Today*, *64*, 21–26. https://doi.org/10.1016/j.nedt.2018.01.030

Sinclair, S., Beamer, K., Hack, T. F., McClement, S., Raffin Bouchal, S., Chochinov, H. M., & Hagen, N. A. (2016). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliative Medicine*, *31*(5), 437–447. https://doi.org/10.1177/0269216316663499

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology, 24*(18), 875–878. https://doi.org/10.1016/j.cub.2014.06.054

Slade, S., & Sergent, S. R. (2023). *Interview Techniques.* Stat Pearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK526083/

Smythe, E. A., Ironside, P. M., Sims, S. S., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies, 45,* 1389–1397. https://doi.org/10.1016/j.ijnurstu.2007.09.005

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research,* 104, 333–339. https://doi.org/10.1016/j.jbusres.2019.07.039

Sol, K. & Heng, K. (2022). Understanding epistemology and its key approaches in research. *Cambodian Journal of Educational Research. 2*(2), 80–99. https://doi.org/10.62037/cjer.2022.02.02.05

Song, Y., Lafond, C. M., Vincent, C., Kim, M. J., Park, C. G., & McCreary, L. L. (2024). Critical soft skill competencies that clinical nurse educators consider important

to evaluate in nurses. *Nursing Open, 11*(10), Article 70047. https://doi.org/10.1002/nop2.70047

Stacey, G., Wilson, C., Reddy, H., Palmer, C., Henderson, J., Little, H., & Bull, H. (2018). Diagnosing and treating enquiry-based learning fatigue in graduate entry nursing students. *Nurse Education in Practice*, *28*, 310–313. https://doi.org/10.1016/j.nepr.2017.09.006

Statistics New Zealand. (n.d). 2018 *New Zealand Census Population and Dwellings.* New Zealand Government. https://www.stats.govt.nz/information-releases/2018-census-population-and-dwelling-counts#update

Stroh, K. M. (2015). Intersubjectivity of Dasein in Heidegger's "Being and Time": How authenticity is a return to community. *Human Studies*, *38*(2), 243–259. http://www.jstor.org/stable/24757333

Sürücü, H. A., Topdemir, E. A., Baksi, A., & Besen, D. B. (2021). Empathic approach to reducing the negative attitudes of nursing undergraduate students towards cancer, *Nurse Education Today,* 105, Article 105039. https://doi.org/10.1016/j.nedt.2021.105039

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226–231. https://doi.org/10.4212/cjhp.v68i3.1456

Svenaeus, F. (2000). *The hermeneutics of medicine and phenomenology of health: Steps towards a philosophy of medical practice.* Dordrecht, Kluwer Academic Publishers.

Schwartz, M., & Abbott, A. (2007). Storytelling: a clinical application for undergraduate nursing students. *Nurse Education in Practice*, *7*(3), 181–186. https://doi.org/10.1016/j.nepr.2006.06.005

Tan, Y. S. M. & Caleon, I. S. (2022). "It's not just about grades": Teachers' alternative perceptions of students performing at a low level and of these students' academic success. *Teaching and Teacher Education, 118*, Article 103816. https://doi.org/10.1016/j.tate.2022.103816

Todres, L., Galvin, K. T., & Holloway, I. (2009). The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-Being*, *4*(2), 68–77. https://doi.org/10.1080/17482620802646204

Tolosa-Merlos, D., Moreno-Poyato, A. R., González-Palau, F., Pérez-Toribio, A., Casanova-Garrigós, G., Delgado-Hito, P., & MiRTCIME.CAT Working Group (2023). Exploring the therapeutic relationship through the reflective practice of nurses in acute mental health units: A qualitative study. *Journal of Clinical Nursing*, *32*(1-2), 253–263. https://doi.org/10.1111/jocn.16223

Tomkins, L., & Simpson, P. (2015). Caring leadership: A Heideggerian perspective. *Organization Studies, 36*(8), 1013–1031. https://doi.org/10.1177/0170840615580008

Toulson Davisson Correia, M. I. (2023). Ethics in research, *Clinical Nutrition Open Science, 47*, 121-130. https://doi.org/10.1016/j.nutos.2022.12.010

Tunks Leach, K. J., Barker, M. E., Hales, C., Holmberg, B., Holmberg, M., Jakimowicz, S., Rook, H., Sherwood, G., Streit, L., & Levett-Jones, T. (2025). Perceptions of empathic and compassionate healthcare encounters: An international exploratory qualitative descriptive study. *Scandinavian Journal of Caring Sciences*, *39*(2), e70006. https://doi.org/10.1111/scs.70006

University of Auckland. (n.d.-a). *Master of Nursing.* University of Auckland. https://www.auckland.ac.nz/en/study/study-options/find-a-study-option/master-of-nursing-mnurs.html

University of Auckland. (n.d.-b). *Master of Nursing Science.* University of Auckland. https://www.auckland.ac.nz/en/study/study-options/find-a-study-option/master-of-nursing-science-mnsc.html#:~:text=The%20two%2Dyear%20(240%20point,compromising%20on%20quality%20of%20training

Urcia, I. A. (2021). Comparisons of adaptations in grounded theory and phenomenology: Selecting the specific qualitative research methodology.

International Journal of Qualitative Methods, 20. 1–14. https://doi.org/10.1177/16094069211045474

Usher, K. (2006). Nursing education in 2006. *Journal of Advanced Nursing, 53(3)*, 261–262. https://doi.org/10.1111/j.1365-2648.2006.03654.x

Valerio, M. A., Rodriguez, N., Winkler, P., Lopez, J., Dennison, M., Liang, Y., & Turner, B. J. (2016). Comparing two sampling methods to engage hard-to-reach communities in research priority setting. *BMC Medical Research Methodology, 16*(1), Article 146. https://doi.org/10.1186/s12874-016-0242-z

van Dijke, J., van Nistelrooij, I., Bos, P., & Duyndam, J. (2020). Towards a relational conceptualization of empathy. *Nursing Philosophy: An International Journal for Healthcare Professionals*, *21*(3), e12297. https://doi.org/10.1111/nup.12297

van Manen, M. (2017). Phenomenology in its original sense. *Qualitative Health Research, 27*(6), 810-825. https://doi.org/10.1177/1049723217699381

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing.* Walnut Creek, CA: Left Coast Press Inc.

van Manen, M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. State University of New York Press.

Vega, H., & Hayes, K. (2019). Blending the art and science of nursing. *Nursing*, *49*(9), 62–63. https://doi.org/10.1097/01.NURSE.0000577752.54139.4e

Vellem, B., & Jooste, K. (2025). Preceptors inspire students to be competent in nursing practice in a psychiatric public unit. *Journal of Interdisciplinary Health Science*, *30*, Article 2899. https://doi.org/10.4102/hsag.v30i0.2899

Vieten, C., Rubanovich, C. K., Khatib, L., Sprengel, M., Tanega, C., Polizzi, C., Vahidi, P., Malaktaris, A., Chu, G., Lang, A. J., Tai-Seale, M., Eyler, L., & Bloss, C. (2024). Measures of empathy and compassion: A scoping review. *PloS One*, *19*(1), 1–21. https://doi.org/10.1371/journal.pone.0297099

Waterfield, D., & Barnason, S. (2022). The integration of care ethics and nursing workload: A qualitative systematic review. *Journal of Nursing Management*, *30*(7), 2194–2206. https://doi.org/10.1111/jonm.13723

Watson J. (2008). Social justice and human caring: A model of caring science as a hopeful paradigm for moral justice for humanity. *Creative Nursing*, *14*(2), 54–61. https://pubmed.ncbi.nlm.nih.gov/18655513/

Willis, J. (2021). *National Nursing Student Survey 2021 Report.* New Zealand Nurses Organisation. https://www.nzno.org.nz/Portals/0/publications/Report%20-%20National%20Nursing%20Student%20Survey,%202021.pdf

Wilson, D., Mikahere-Hall, A., & Sherwood, J. (2021). Using indigenous kaupapa Māori research methodology with constructivist grounded theory: Generating a theoretical explanation of indigenous women's realities. *International Journal of Social Research Methodology*, *25*(3), 375–390. https://doi.org/10.1080/13645579.2021.1897756

Wilson, D., Barton, P., & Tipa, Z. (2022). Rhetoric, Racism, and the Reality for the Indigenous Māori Nursing Workforce in Aotearoa New Zealand. *OJIN: The Online Journal of Issues in Nursing, 27*(1). https://www.doi.org/10.3912/OJIN.Vol27No01Man02

Winnington, R., Shannon, K., Turner, R., Jarden, R., McClunie-Trust, P., Jones, V., Merrick, E., Donaldson, A. & Macdiarmid, R. (2023). Learning experiences of first year graduate entry nursing students in New Zealand and Australia: A qualitative case study. *BMC Nursing. 22,* Article 74. https://doi.org/10.1186/s12912-023-01233-9

Winter, R., Leanage, N., Roberts, N., Norman, R.I. & Howick, J. (2022). Experiences of empathy training in healthcare: A systematic review of qualitative studies. *Patient Education and Counseling, 105*(10), 3017-3037, https://doi.org/10.1016/j.pec.2022.06.015

Wiseman, T. (1996). A concept analysis of empathy. *Journal of Advanced Nursing*, *23*, 1162–1167. https://doi.org/10.1046/j.1365-2648.1996.12213.x

World Health Organisation (2019). *Burn-out an "occupational phenomenon": International Classification of Diseases.* World Health Organisation. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

Wrathall, M. (2025). *Martin Heidegger*. In E. N. Zalta & U. Nodelman (Eds.), *The Stanford Encyclopaedia of Philosophy* (Spring 2025 Edition). Stanford University. https://plato.stanford.edu/archives/spr2025/entries/heidegger/

Xu, J., Zhang, L., Ji, Q., Ji, P., Chen, Y., Song, M., & Guo, L. (2023). Nursing students' emotional empathy, emotional intelligence and higher education-related stress: A cross-sectional study. *BMC Nursing*, *22*(1), 437. https://doi.org/10.1186/s12912-023-01607-z

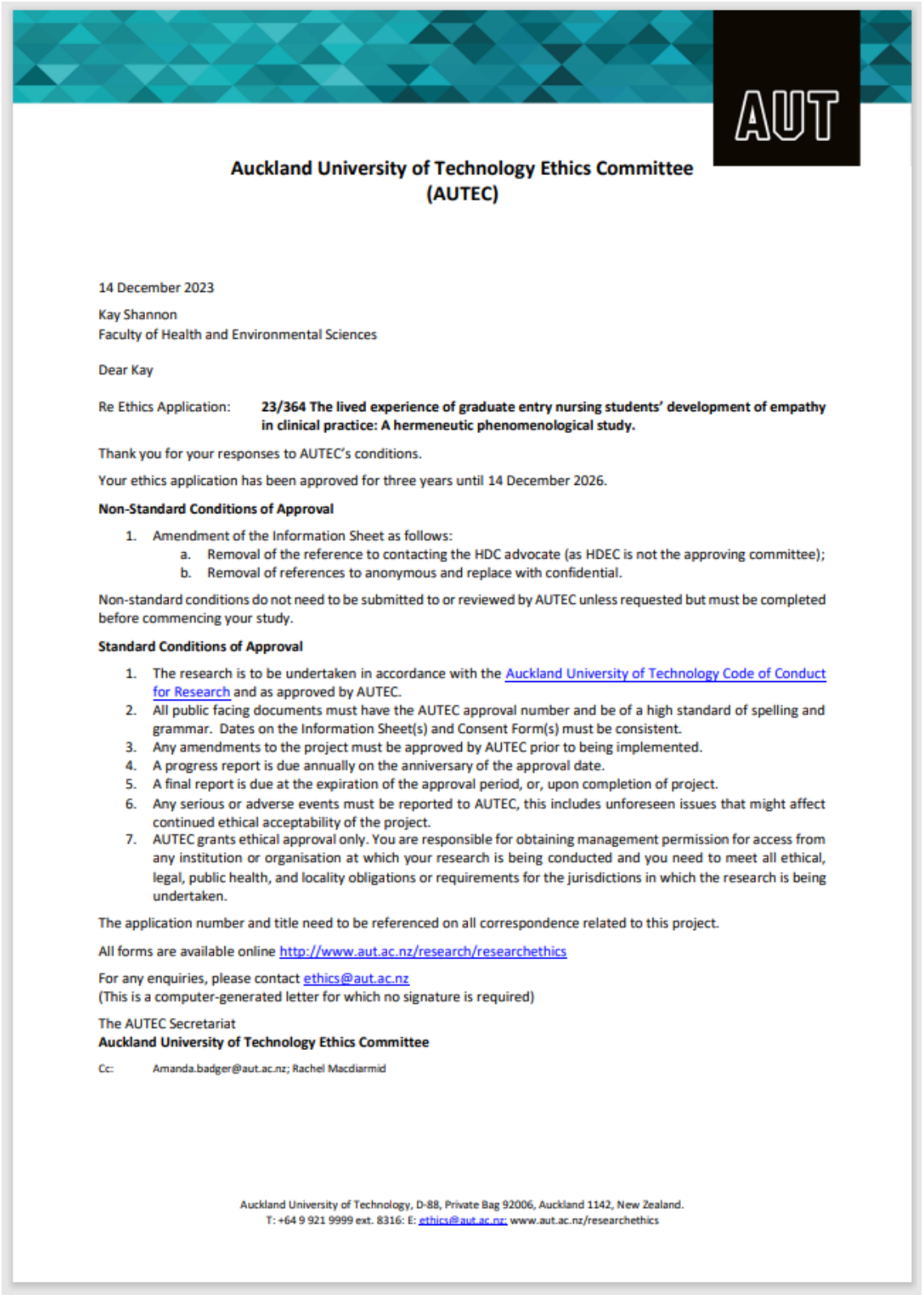
Yang, Q., & Zou, W. (2025). The impact of reflective practice on the development of nursing undergraduate students. *BMC Medical Education*, *25*(1), 880. https://doi.org/10.1186/s12909-025-07490-3

Yu, C. C., Tan, L., LE, M. K., Tang, B., Liaw, S. Y., Tierney, T., Ho, Y. Y., Lim, B. E. E., Lim, D., Ng, R., Chia, S. C., & Low, J. A. (2022). The development of empathy in the healthcare setting: A qualitative approach. *BMC Medical Education*, *22*(1), Article 245. https://doi.org/10.1186/s12909-022-03312-y

Yu, J., & Kirk, M. (2009). Evaluation of empathy measurement tools in nursing: Systematic review. *Journal of Advanced Nursing*, *65*(9), 1790–1806. https://doi.org/10.1111/j.1365-2648.2009.05071.x

Appendices

Appendix A: *Ethics Approval*



Auckland University of Technology Ethics Committee (AUTEC)

14 December 2023

Kay Shannon
Faculty of Health and Environmental Sciences

Dear Kay

Re Ethics Application: **23/364 The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 14 December 2026.

Non-Standard Conditions of Approval

1. Amendment of the Information Sheet as follows:
   a. Removal of the reference to contacting the HDC advocate (as HDEC is not the approving committee);
   b. Removal of references to anonymous and replace with confidential.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@aut.ac.nz
(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Amanda.badger@aut.ac.nz; Rachel Macdiarmid

Auckland University of Technology, D-88, Private Bag 92006, Auckland 1142, New Zealand.
T: +64 9 921 9999 ext. 8316: E: ethics@aut.ac.nz; www.aut.ac.nz/researchethics

Appendix B: *Letter to Tertiary Institutes*

Access Agreement

8 February 2024

Research Title:
The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.

Supervisors: Dr Kay Shannon and Dr Rachel Macdiarmid
Researcher: Amanda Badger

Kia ora,

My name is Amanda Badger, a Registered Nurse, and Master of Philosophy student at Auckland University of Technology (AUT). I am conducting research under the supervision of Dr Kay Shannon and Dr Rachel Macdiarmid. My research will investigate the lived experience of second-year Graduate Entry Nursing (GEN) students in developing empathy in clinical practice.

The Auckland University of Technology Ethics Committee has approved my research proposal. AUTEC reference number: 23/364.

I invite you to consider taking the time to read this letter, and the Participant Information Sheet (PIS) attached to the email.

About the Research

This qualitative study aims to understand the lived experience of GEN students' development of empathy in clinical practice in Aotearoa New Zealand. Empathy is a fundamental nursing skill, and a graduate attribute, as it facilitates a safe patient-nurse relationship and improves health outcomes. To ensure necessary support and education are provided to the GEN students, an understanding of their lived experience of empathy development in clinical practice is essential. This study provides an opportunity for participants to express their lived experiences of empathy development in clinical practice through narration. The findings of this research may be used for academic publications and presentations.

What am I seeking an access agreement to?

- I would like permission to invite your students to participate in my study as I am seeking voluntary participation from one or two students from your institution. These students will be interviewed in a one-off interview taking up to 60 minutes.
- I would like permission to come to your tertiary institution and speak to your students face to face about the study, as it humanises the research and researcher, potentially leading to increased interest in participation.
- I am seeking access to your tertiary institute's online Learning Management System notice boards/Research notice boards/appropriate courses to advertise the study online and I am seeking permission to post the research advertisements in student spaces. I expect the study would be advertised at your institute for approximately three months unless negotiations were made to extend the advertising time.

Thank you for your time and consideration. I hope to hear from you soon.

Ngā mihi nui,

Amanda Badger

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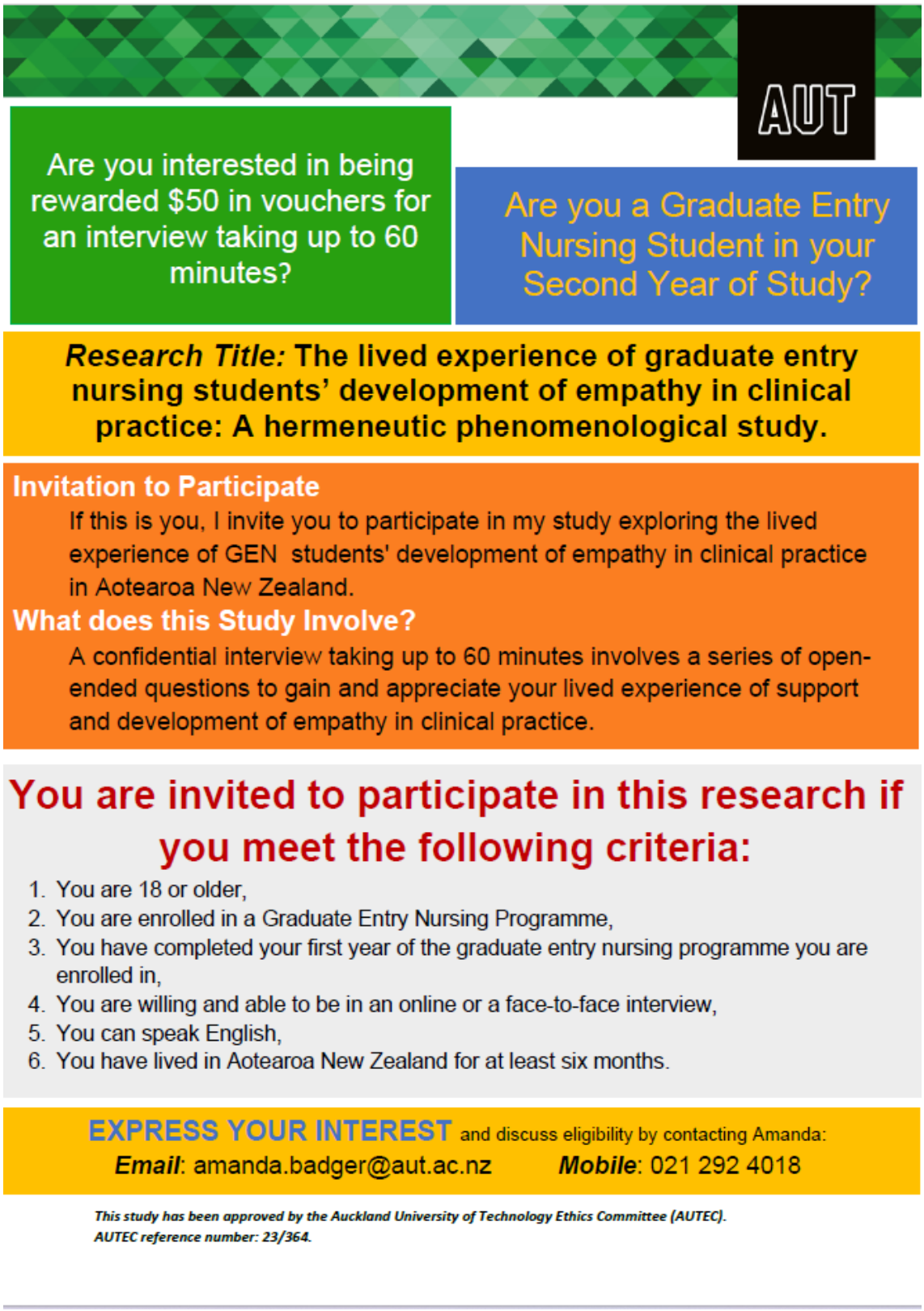
Research Supervisor Contact Details
Dr Kay Shannon
Phone: 09 921 9999 ext 7765
Email: kay.shannon@aut.ac.nz

Co-Research Supervisor Contact Details
Dr Rachel Macdiarmid
Phone: 09 921 9999 ext 7687
Email: rachel.macdiarmid@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on December 14th 2023 AUTEC Reference number 23/364

Appendix C: *Advertisement Poster*



Appendix D: *Participant Information Sheet (PIS)*

PARTICIPANT INFORMATION SHEET

Date Information Sheet Produced:

14 December 2023

Research Title:

The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.

Supervisors: Dr Kay Shannon and Dr Rachel Macdiarmid

Researcher: Amanda Badger

A Welcome Note

Kia ora,

My name is Amanda Badger, a Registered Nurse and Master of Philosophy student at Auckland University of Technology (AUT). My research supervisors are Dr Kay Shannon and Dr Rachel Macdiarmid.

I deeply appreciate your interest and consideration in participating in my research and for contributing to the research exploring the lived experience of empathy development as a Graduate Entry Nursing (GEN) student in clinical practice. At any stage, if you have any queries, please do not hesitate to contact me via email at: amanda.badger@aut.ac.nz.

This study has been approved by the Auckland University of Technology Ethics Committee (AUTEC). AUTEC reference number: 23/364 on December 14th 2023.

About the Research

In 2014, the GEN programme was approved by the Nursing Council of New Zealand as an alternative pathway to nursing registration in Aotearoa New Zealand. This means graduates of any discipline who aspired to be a registered nurse can now gain a high qualification (a master's degree) and a nursing qualification together. As this degree has only been offered for ten years in Aotearoa New Zealand, limited research and literature is exploring GEN students specifically in Aotearoa New Zealand. Exploring the lived experience of GEN students and the development of empathy in clinical settings is important to ensure necessary support and education are provided to the GEN students, an understanding of their lived experience of empathy development and support in clinical practice is required. Empathy is a fundamental nursing skill, and a graduate attribute, as it facilitates a safe patient-nurse relationship and improves health outcomes.

The aim of this study is to understand the lived experience of GEN students to develop of empathy in clinical practice. This study provides an opportunity for participants to express their lived experiences of empathy development from their clinical practice experiences through narration. The findings of this research may be used for academic publications and presentations.

Eligibility Criteria

You're invited to participate in this research if you meet the following criteria:

1. You are 18 or older,
2. You are enrolled in a Graduate Entry Nursing Programme,
3. You have completed your first year of the graduate entry nursing programme you are enrolled in,
4. You are willing and able to be in an online or a face-to-face interview,
5. You can speak English,
6. You have lived in Aotearoa New Zealand for at least six months.

Participation in this research is voluntary and your details will be kept completely confidential.

Research Procedures

You will be provided with a consent form to read through and sign if you agree to the research terms and conditions. After I have received the signed consent form, a confirmation email will be sent to arrange a date, time, and location that suits you for an interview. You will have the option to choose between an online interview (via Microsoft Teams) or a face-to-face interview (at a convenient location that enables confidentiality at your university campus). You are also able to shift your interview approach at any time (please email me with your change before we meet). You are welcome to bring a whānau/family member or a friend to support you here.

If the criteria has not been met or the number of participants for the study has reached its full capacity, you will receive an email declining participation in the study at that time. However, you may be contacted by the primary researcher at a later date if more participants are needed for the study. Again, you are allowed to decline this offer made by the primary researcher.

Interview Process

This study involves a one-off interview of approximately 60 minutes. There is a set of open-ended questions that I will ask you to answer during the interview session. You do not need to do anything to prepare for the interview. The questions will be about your clinical experience and how you develop empathy. The interview will be conversational. The interview will be recorded for transcription purposes, however, all identifiable information from the interview transcription will be removed or changed to promote confidentiality. You have the right to refuse to answer any questions or ask me to stop or pause the recording at any time.

Post-Interview Process

I will transcribe the recording as soon as possible after each interview. Interviews will be recorded and transcribed using Otter AI for data analysis. I will then review the transcription whilst listening to the recording to ensure the accuracy of the transcription. An electronic copy of the transcription will be sent to your email. You will be able to review and check the transcript before it is finalised as data for this study. This means you have a second opportunity to (refuse/remove any content you do not want to be included).

You will have two weeks to complete this work before I start analysing your interview. If you have any changes, please email your amended file back to me. If no comments on the revisions are sent back after two weeks, I will assume that you have approved the original draft.

Please note, that the research supervisor, Dr Shannon and Dr Macdiarmid will have access to the deidentified interview transcriptions only. This is to maintain confidentiality.

Data Use, Storage, Retention, and Destruction

Please be assured that all data collected during the registration and the interviews will be used only for research purposes and for future publications and conference presentations. All data (registered information, recordings, and transcriptions) will be collected and stored digitally. Contact details will be kept in an Outlook folder and deleted after the study. Consent forms will be stored in a separate folder for six years. Audio recordings and transcripts of the interviews will be stored in the Auckland University of Technology (AUT) password-protected computer system for six years. Thereafter, all the data will be permanently deleted from the Auckland University of Technology computer system.

Right to Withdraw from Participation

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What do I do if I have Concerns About this Research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Kay Shannon, kay.shannon@aut.ac.nz, 09 921 9999 ext 7765.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

What are the Discomforts and Risks?

The potential risks you may encounter with this study are sensitivity and confidentiality.

These risks mean that:

a) The topics covered in the interview will revolve around your clinical placement experience, empathy knowledge and empathy development in the clinical placement. This information will be shared through storytelling, which might make you feel uncomfortable or embarrassed.
b) Your identity (e.g., real name and contact information) is (only) known to me.

To minimise these potential risks, the following strategies have been made for you:

- You are welcome to choose your own pseudonym which will be used to deidentify you in the interview transcriptions.
- Your identity will be kept confidential.
- I will be the only person who listens to your recordings and transcribes them.
- You do not need to answer any question(s) that make you feel uncomfortable or do not want to answer.
- You will have the right to delete a part or the whole of your interview transcription if you feel that the information can be traceable, or you would like to unenroll in the study (up to two weeks after the interview).
- Your research data will be described as de-identified and, in any report or discussion of the information given by you will be done in a way that does not identify you as the source of the information.
- Your identifiable information will be removed and kept separately in AUT OneDrive folder. Your research data will be kept in a secure spreadsheet in my university password-protected folder.
- A summary of the research findings will be available to you once the thesis is complete. If you would like to receive a copy, please indicate your email address on the consent form.

AUT Student Counselling and Mental Health can offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9292.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling at https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

Whom Do I Contact for Further Information About This Research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details

Amanda Badger
Master of Philosophy Student
School of Clinical Sciences
Auckland University of Technology
Phone: +64 212 924 018
Email: amanda.badger@aut.ac.nz

Research Supervisor Contact Details

Dr Kay Shannon
Senior Lecturer
School of Clinical Sciences
Auckland University of Technology
Phone: 09 921 9999 ext 7765
Email: kay.shannon@aut.ac.nz

Dr Rachel Macdiarmid
Head of Nursing
School of Clinical Sciences
Auckland University of Technology
Phone: 09 921 9999 ext 7687
Email: rachel.macdiarmid@aut.ac.nz

Appendix E: *Consent form (written)*

CONSENT FORM

Project title:
The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.

Project Supervisors: **Dr Kay Shannon and Dr Rachel Macdiarmid**

Researcher: **Amanda Badger**

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 14th December 2024.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes☒ No☒

Participant's signature: .....

Participant's name: .....

Participant's Contact Details:

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on December 14th 2023 AUTEC Reference number 23/364

Note: The Participant should retain a copy of this form

Appendix F: *Consent form (verbal)*

Oral Consent Protocol

Project title:
The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.

Project Supervisors: Dr Kay Shannon and Dr Rachel Macdiarmid
Researcher: Amanda Badger

The participant joins the videoconference.

- ○ Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated and they will be asked the following:

- ○ Have you read and understood the information provided about this research project in the Information Sheet dated December 14th 2023?
- ○ Do you have any questions about the research?
- ○ Do you understand that notes will be taken during the interviews and that the interview will also be audio- recorded and transcribed?
- ○ Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?
- ○ Do you understand that if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used? However, once the findings have been produced, removal of your data may not be possible.
- ○ Do you agree to take part in this research?
- ○ Do you wish to receive a summary of the research findings? (please tick one): Yes☒ No☒
- ○ Do you want me to send you a copy of the audio recording for this consent? Yes☒ No☒
- ○ Please confirm you name and contact details

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

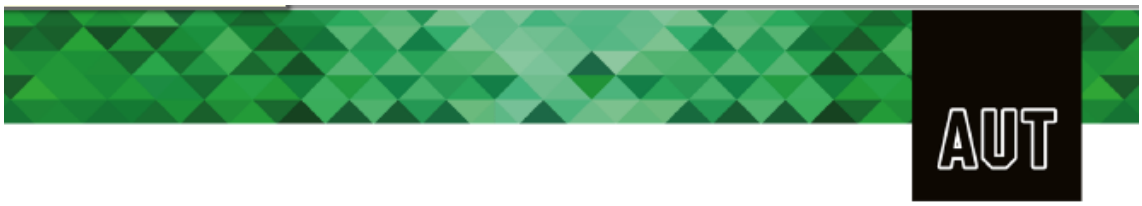
.....

I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 14th December 2024 AUTEC Reference number 23/364

Note: The Participant should retain a copy of this form.

Appendix G: *Participant Registration Form*



REGISTRATION INFORMATION SHEET

Research Title:

The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.

Supervisors: Dr Kay Shannon and Dr Rachel Macdiarmid
Researcher: Amanda Badger

Thank you for reading the Participant Information Sheet and agreeing to take part in this study. The Registration Information sheet has two parts. Please complete bother parts, then sign and date the registration form to complete the registration process.

Part One – To help us analyse the data for the study, we need to know a little about you:

1. **What is your ethnicity?**
   ☐European
   ☐Māori
   ☐Pasifika
   ☐Asian
   ☐Middle Eastern
   ☐Latin American
   ☐African
   ☐Other
   ☐Prefer not to say

2. **What is your gender?**
   ☐Female
   ☐Male
   ☐Non-binary/third gender
   ☐Prefer not to say

3. **What is your age?**
   Click or tap here to enter text.

4. **What is your undergraduate degree?**
   Click or tap here to enter text.

5. **What tertiary institution are you enrolled in?**
   Click or tap here to enter text.

6. **How many clinical placements have you taken part in the programme to date?**

   Click or tap here to enter text.

7. **How many hours of clinical placement have you completed in the GEN programme?**
   Click or tap here to enter text.

Part Two – To help schedule an interview with you, we invite you to indicate your preferred date, time and verbal preference:

1. **What date and time would you like to attend the interview?**
   Please indicate two preferred dates and times below:

Preference one:

Date: Click or tap to enter a date. **(dd/mm/yyyy);**

Time: Click or tap here to enter text. **(example time 14:00-15:00);**

Preference two:

Date: Click or tap to enter a date. **(dd/mm/yyyy);**

Time: Click or tap here to enter text. **(example time 14:00-15:00)**

2. **How would you like to be interviewed?**
   ☐In person at a convenient location that enables confidentiality at your university campus

   ☐An online meeting via Microsoft Teams

3. **Would you like to invite someone from your whānau to participant in the interview with you for support?**
   ☐Yes

   ☐No

Signature.....

Name.....

Date.....

Approved by the Auckland University of Technology Ethics Committee on December 14th 2023 AUTEC Reference number 23/364

Note: The Participant should retain a copy of this form

Appendix H: *Amendment 1*

Auckland University of Technology Ethics Committee
(AUTEC)

1 August 2024

Kay Shannon
Faculty of Health and Environmental Sciences

Dear Kay

Re: Ethics Application: **23/364 The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.**

Thank you for your request for approval of amendments to your ethics application.

The amendments to include "snowballing" in the recruitment protocol and readvertise the study in October has been approved.

Non-Standard Conditions of Approval

1. Amendment of the Information sheet to include the additional recruitment method in the "how was I identified" section.
2. Amendment of the advertisement to include passing the flyer on to someone who may be interested.

Of note, a finalised Information Sheet is not on AUTEC file, therefore please forward once it is updated from the NSCs.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@aut.ac.nz

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Amanda.badger@aut.ac.nz; Rachel Macdiarmid

Appendix I: *Amendment 2*

Auckland University of Technology Ethics Committee (AUTEC)

10 October 2024

Kay Shannon
Faculty of Health and Environmental Sciences

Dear Kay

Re: Ethics Application: **23/364 The lived experience of graduate entry nursing students' development of empathy in clinical practice: A hermeneutic phenomenological study.**

Thank you for your request for approval of amendments to your ethics application.

The minor amendments to the recruitment protocol (advertisement via social media) ~~has~~ been approved.

Non-Standard Conditions of Approval

1. For the privacy of all involved ensure that comments are turned off for social media posts. Should a potential participant want to ask the researcher a question about the study the post they can directly contact the researcher.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact the Secretariat at ethics@aut.ac.nz

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Amanda.badger@aut.ac.nz; Rachel Macdiarmid

Appendix J: *Participant Information and Particulars*

Pseudonym	Gender	Ethnicity	Age
George	Female	European/Pākeha	26
Frankie	Female	European/Pākeha	23
Kaia	Female	Asian	34
Mārama	Female	Māori/European/Pākeha	27
Penelope	Female	Asian	23
Sam	Female	Asian	42
Summer	Female	European/Pākeha	40

Appendix K: *Presupposition Interview Prompt Questions*

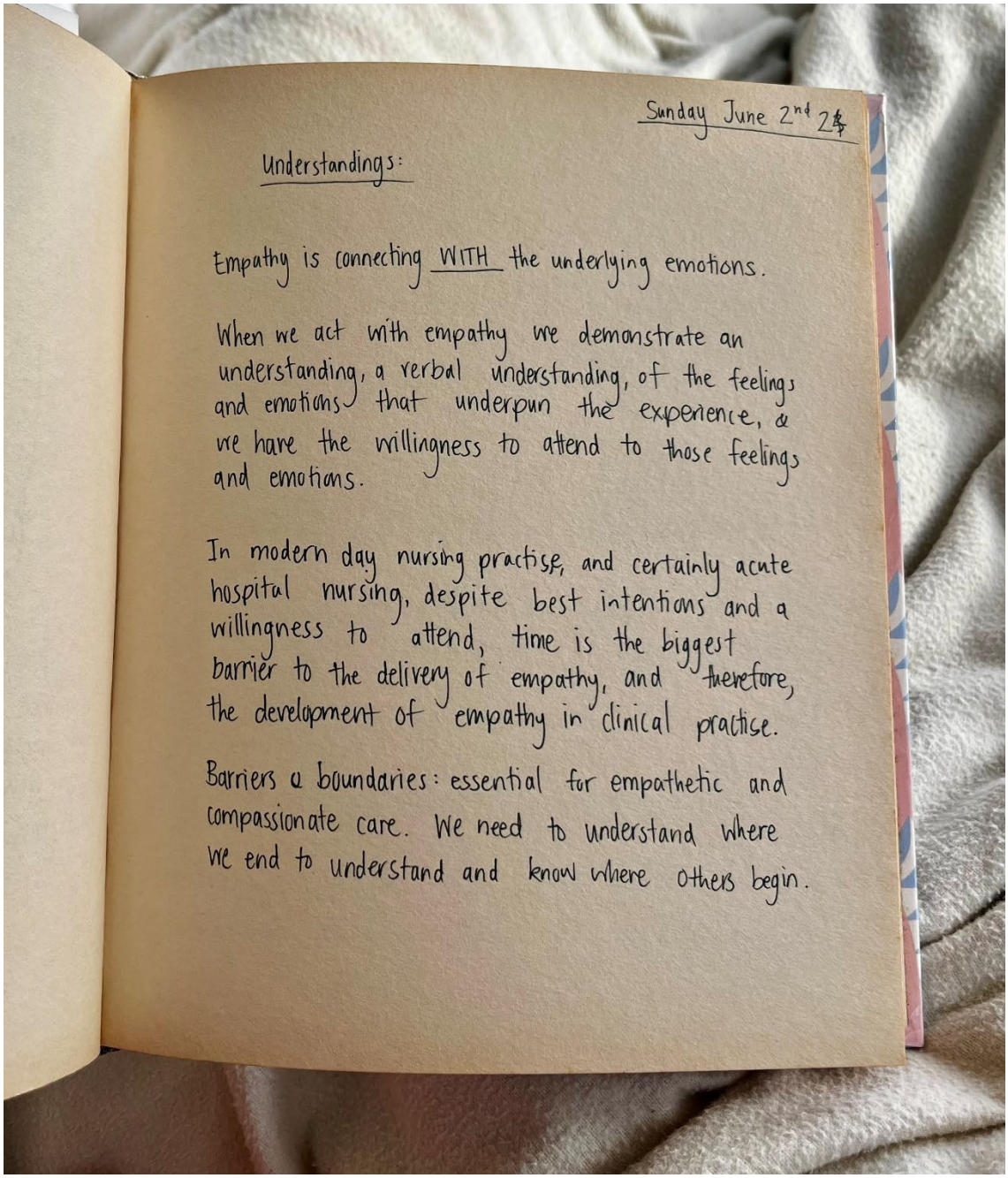
Structure	Reason	Prompt Question(s) / Guidance
Ontology	To develop an understanding of the nature of being via personal / professional experience.	• Imagine someone you didn't know asked you to describe yourself. o What words would you use and why? o What would be important for them to know? • Tell me the story of what has led you to your current role – start from wherever you want to. • Why did you choose to do an EdD at the time you did? • What do you envisage the EdD will give you?
Epistemology	To clarify assumptions about what knowledge is.	• How did you decide on your subject area? • Why is this subject important to you? • What do you hope to achieve through your research?
Research Question	To elicit origins of subject focus.	• How did you develop your research question(s)? • Why did you choose the question(s)?
Paradigm	To recognise beliefs about approaches to research.	• What factors were involved in choosing your research paradigm? • What challenges/opportunities did this decision present for you?
Methodology	To identify notions about how we find out about things.	• What was the process of selecting your methodology? • What are the opportunities and challenges presented by your methodology?
Methods	To examine the underpinning decision-making for research tools.	• How did you decide on your research tools? • What are your hopes/concerns about your research tools?
Summary	To offer a visual recap.	• On the paper provided, use words/symbols/pictures to sum up what you have gained from this experience.

Figure 1. Presuppositional interview prompts © Goldspink, 2022

Appendix L: *Indicative Interview Questions*

Structure	Reason	Prompt Question(s)
Ontology	To develop an understanding of the lived experience	• Can you tell me, what is your understanding of empathy? • Can you tell me a little more about this understanding of empathy and if this is something that has been taught to you in your nursing programme or was this something you already knew before commencing the nursing programme? • Can you tell me a story about a moment from your clinical practice experience that stands out for you where you have experienced or seen empathy demonstrated? • Can you tell me about a time when you have discussed empathy with someone in clinical practice? • Tell me about a role model of empathetic nursing you have seen in clinical practice. • Who was this and what was the situation? • What traits did you see in them that aligned with your understanding of empathy? • Can you tell me what would help you develop empathy and empathetic nursing skills? • Can you describe and explain what influences your ability to act empathetically in clinical practice?

Appendix M: *Reflective Journal*



Sunday June 2nd 25

Understandings:

Empathy is connecting WITH the underlying emotions.

When we act with empathy we demonstrate an understanding, a verbal understanding, of the feelings and emotions that underpin the experience, & we have the willingness to attend to those feelings and emotions.

In modern day nursing practise, and certainly acute hospital nursing, despite best intentions and a willingness to attend, time is the biggest barrier to the delivery of empathy, and therefore, the development of empathy in clinical practise.

Barriers & boundaries: essential for empathetic and compassionate care. We need to understand where we end to understand and know where others begin.