Empathetic Partnership: An Interdisciplinary Framework for Primary Care Practice
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ABSTRACT
This article introduces Empathetic Partnership, an interdisciplinary framework for primary care practice in the United States. The framework provides a practice framework for primary care nurse practitioners to create effective and therapeutic partnerships with patients. Empathetic Partnership uses women who have sex with women as an exemplar of a marginalized population. Empathetic Partnership is influenced by the lead author’s previous work; the cultural safety work of Dr Irihapeti Ramsden, a nurse; and sociologist Dr Brené Brown. The framework consists of 6 key elements: reflection, environment, language, knowledge, partnership, and empathy.

Keywords: Brené Brown, cultural safety, empathetic partnership, interdisciplinary, Irihapeti Ramsden, women who have sex with women

Most patients experience some sense of vulnerability and uncertainty when interacting with nurse practitioners (NPs), other providers, and the health care system in general. Patients are often asked to discuss the most intimate parts of their lives with NPs and other clinicians. Patients are asked to discuss personal health status, daily practices, relationships, sexuality, and much more. Because of the vulnerability of those seeking health care, it is important for NPs to focus on creating safe environments and effective and meaningful partnerships with patients in order to elicit information and to build trust for collaboration on both client-centered and mutual goals.

The purpose of this article is to introduce an interdisciplinary framework, Empathetic Partnership, which adds new concepts to the primary author’s previous work “Creating a Safe and Caring Health Care Context for Women Who Have Sex With Women.” The Empathetic Partnership framework will be used to show key components for practice as a way for NPs to establish safe, effective, and meaningful partnerships with patients.

Empathetic Partnership is influenced by the concepts of New Zealand nursing’s cultural safety, the teachings of the architect of cultural safety Dr Irihapeti Ramsden, and the work of Dr Brené Brown, a sociologist in the United States. Because of the influences of cultural safety concepts and the work of Ramsden and Brown, these interdisciplinary factors are discussed in this article. Because they inform and validate Empathetic Partnership, they will be referenced commonly and used to illustrate the key elements of the framework. To further illustrate the framework, women of sexual minority are used as the example of a marginalized population.

The Empathetic Partnership is a needed addition to the nursing profession because “nursing has lagged behind medicine, social work, and other professions in the publication of research studies, theoretical frameworks, and practice guidelines about LGBT [lesbian, gay, bisexual and transgender] health.” This framework can be used with all patients but is specifically useful when providing care for individuals or families from marginalized populations.
Empathetic Partnership comprises 6 elements: reflection, environment, language, knowledge, partnership, and empathy. Empathetic Partnership expands the primary author’s previous unnamed framework of 4 elements (reflection, environment, language, and knowledge) to 6. The previous 4-element framework was informed by concepts of New Zealand’s cultural safety and is a synthesis of the primary tenets of cultural safety and the primary author’s own ideas and concepts. After extensively researching Dr Brené Brown’s work as a US sociologist, 2 more concepts were added to the original unnamed framework. Brown’s Acompañar theory, as well as her more recent research on shame resilience, vulnerability, authenticity, and empathy are synthesized in this article. The 2 added key components are partnership and empathy, and the framework was subsequently named Empathetic Partnership. Brown influences the addition of the partnership component because, while this concept has roots in cultural safety, it is also emphasized and researched in her Acompañar theory and subsequent research. Although Brown’s work as a US sociologist enhances all the key components of the Empathetic Partnership framework, her work specifically brings in the empathy component, a concept that is well described in her research.

A frequently marginalized and stigmatized group within contemporary society is women of sexual minority or women who have sex with women (WSW). Sometimes referred to as lesbian or bisexual, many WSW do not self-identify in those terms. Therefore, using WSW is more inclusive because of the varying self-identifications of women and the inherent fluidity of sexuality. As stated in the author’s previous work, WSW have faced historical invisibility, mistrust, and abuse and have suffered marginalization and stigma not only in society as a whole but also within the health care system. It is acknowledged that many WSW have also had positive experiences of being cared for in safe, effective, and therapeutic ways within health care and that many NPs are well established in creating safe partnerships with WSW patients. However, the lack of safe, effective working partnerships with patients is all too common and pervasive in our health care system. Having a history of minority status, stigma, abuse, and marginalization, the WSW populations provide an excellent opportunity to illustrate the prevailing need for NPs in clinical practice to use the Empathetic Partnership framework.

DEVELOPMENTAL INFLUENCES ON EMPATHETIC PARTNERSHIP: CULTURAL SAFETY, RAMSDEN, AND BROWN

Introduced in the 1980s in New Zealand, cultural safety began as a concept and developed into a conceptual guide informing nursing education and practice with influences from critical social and feminist theory in the nursing profession. Cultural safety is defined as “the effective nursing practice of a person or family from another culture, and is determined by that person or family.” Cultural safety encourages the NP (and all nurses) to recognize and understand the inherent patient-provider power imbalance and to recognize and honor the patient’s culture.

Cultural safety also requires that the NP identify his or her own culture(s), including values and biases, and reflect on how these may affect the relationship with the patient. It calls the NP to establish a health care relationship that respects, nourishes, celebrates, and encourages the individual or family. Culture is defined broadly and refers to “the beliefs and practices common to any particular group of people.” Two important tenets of cultural safety are the need for the NP to exercise self-reflection and establish a trusting partnership between provider and patient. Cultural safety asserts that within the health care context, the patient and his or her culture(s) are the norm, whereas the health care environment is the exotic or other.

There is no doubt that the US is emphasizing the need to address cultural care issues. However, although there are many commonalities between the US ideas around cultural awareness, cultural competency, and cultural sensitivity and New Zealand’s cultural safety, there are also some fundamental differences. Perhaps the biggest difference is that cultural safety specifically addresses the inherent power differentials between patient and provider and emphasizes the importance
of identifying and addressing socioeconomic determinates of health. Common language used in nursing in the US has been focused on caring for patients regardless of their culture or socioeconomic status, whereas cultural safety focuses on a more contemporary view to care for patients regardful of who they are and where they come from. Cultural safety also recognizes that individuals and families are mosaics of culture and that humans are dynamic and commonly identify with more than 1 culture.

Sociologist Brown’s Acompañar theory was developed to assist sociologists and other professionals in creating effective helping partnerships by “accompanying” clients instead of walking in front of them. The emphasis on “accompanying” the client or patient while using empathy and mutual vulnerability is an important factor in the development of the Empathetic Partnership framework. The influences of Brown as they pertain to the key elements of this framework are discussed later in this article.

EMPATHETIC PARTNERSHIP: KEY ELEMENTS
The 6 elements of the Empathetic Partnership framework are described.

Reflection
Reflection is an ongoing process that asks the NP to look at his or her culture(s), including the assumptions and biases inherent in the culture(s), and explore the context of providing care for certain populations. Reflection on one’s own set of beliefs, experiences, perceptions, and biases culminates to identify a culture that is unique to one’s self. This reflective process may enable the NP to identify multiple cultures in others. This presents the opportunity to provide culturally safe care because the personal belief system of an individual can then be viewed as one of many cultures, perceptions, or “truths.” A study by Doutrich et al explored cultural safety in nursing education and practice. The researchers interviewed New Zealand nurses experienced with cultural safety and found that reflection was 1 of the 5 main themes contributing to the core of teaching and practicing with cultural safety. Reflection is “fundamental to cultural safety and to nurses’ authenticity.”

Cultural safety also asks providers “to reflect [on] their own positions of power and privilege within society and health care organizations and how this influences their usually unconscious assumptions and comparisons about ‘others.’” In this context, examining assumptions includes identifying any beliefs the provider may have about WSW populations. Dr Brown discusses the self reflective process as well; she asserts that in order for effective helping to occur, the helping professional must constantly ask himself or herself “what roles and assumptions do I need to question in order to really understand who my client is, what are they experiencing and what do they want and need?” This can be very uncomfortable for some but is essential in providing culturally safe care. An NP cannot practice cultural safety or empathetic partnership without exploring his or her own culture(s), as well as how that culture works as a set of filters, perceptions, and biases that affect his or her view of the world and those in it.

Empathetic Partnership is a way of being in the health care world that is supported by reflection. Cultural safety and Acompañar both support this element. It is important to understand that reflection, especially initially, is about identifying and exploring more than it is about changing or adapting. Understanding that reflection is an ongoing, evolving exercise may make new self-awareness more comfortable for the NP who is a novice to the process of reflection.

Environment
Environment is the most tangible and concrete element involved in the Empathetic Partnership framework. The physical environment in which the health care interaction takes place sets the tone and gives the patient an initial indicator as to whether he or not she is in an open and affirming setting. The environment can be made to be inclusive by making some simple, yet profound, adjustments.

As an example, the WSW patient can easily identify indicators as to how she will be accepted and treated by her evaluation of the art, photographs, reading material, and the presence or absence of a posted nondiscrimination policy. Multiple authors suggest or recommend the value to WSW clients of
seeing health care advertisements in gay media and explicit welcoming promotional materials. Additionally, Brown highlights that the physical environment in which provider/client interaction takes place is 1 indicator as to how vulnerable a client chooses to be with a provider. The social context is also an aspect of environment that may have a powerful influence over how open, trusting, and/or willing to engage the client the provider may be.

Language
Language is powerful and can easily and quickly either isolate patients or let them know they are safe to be as vulnerable and honest as they feel comfortable being. The lexicon used by providers and clinic staff as well as medical forms commonly focus on assumptions of heterosexuality. This assumption can result in the WSW patient feeling she must hide her sexuality from the provider (possibly resulting in purveyance of inaccurate health information). A woman may fear the reaction of the provider if she discloses her sexual orientation, or she may worry that the quality of her health care will be negatively affected. By making a few simple changes to the language used by providers and clinic staff and medical forms, the whole health care experience for the WSW patient can be transformed.

For example, when assessing home life, an NP can ask, “Who lives with you?” or “Who is family to you?” instead of “Do you have a husband?” as a way to invite inclusivity of different cultures and scenarios. Additionally, many NPs ask, “Are you sexually active?” but could easily ask instead “Do you have sex with men, women, both, or none?” Open-ended questions provide opportunities for several different safe answers for the client. It should be noted that language is nuanced and varied across many cultural and geographic landscapes. Identifying and using common language is important in Empathetic Partnership no matter what the cultural mix of the NP and/or client.

Knowledge
Having a knowledge base and practicing with competency for diverse populations and individuals is part of providing quality health care. Although populations are made up of diverse individuals, there are also research-based statistics commonly found among certain populations, including health concerns, disparities, and specific health needs. In terms of the WSW population, what little research is available suggests that there may be higher rates of certain mental, emotional, substance abuse, and physical health conditions and/or cancer risks when compared with the general population.

It is important to consider statistical tendencies of a population when working with an individual patient who “belongs” to a population. Yet, although using any available research is important, it is more important to assess the patient as an individual, not just a member of a statistical population. In addition, understanding the difference between stereotypes (biases) and verifiable research statistics is important to providing culturally safe practice.

And, finally, it is important to realize that statistical tendencies may indicate risk factors but do not predict an individual’s status. For example, stereotypically, some health care providers may believe that lesbian women have sex with only women, whereas, statistically, most women who self-identify as lesbians have had at least 1 male sexual partner. Being able to sensitively elicit information from an individual patient in order to accurately assess the client rather than the client’s population requires an empathetic partnership that includes nuanced language, knowledge, and foundational trust. In addition, the knowledge element includes knowing where and how to access available statistically significant, up-to-date research as part of providing competent and quality care.

Considering the historical contexts for an individual patient may help inform the NP about other potential health care needs. For example, in the WSW population, understanding the historical invisibility and traumas, marginalization, and the subsequent mistrust of health care providers may be integral to establishing a trusting relationship between provider and patient. As Doutrich et al state, “A knowledge and understanding of historical trauma, power difference, and inequity that influence practice” is necessary for providing cultural safety. Additionally, WSW may come from
other marginalized cultures. As Woods\(^3\) posits, the cultural landscape of each individual is wide ranging and complex, so much so that cultural needs of individuals can never be predictable or standardized.

**Partnership and Empathy**

Partnership and empathy, in the context of this framework, are used to describe the relationship between NP and patient that is at the core of a culturally safe and empathetic partnership. Unlike many other nursing and medical models, cultural safety recognizes the inherent power dynamic present in the provider-patient relationship and attempts to not only recognize but to shift the power to a dynamic that is more partnership focused. New Zealand nurses describe this as “standing beside or walking along with the patient” instead of “standing over.”\(^11\) “Walking alongside” in partnership cannot happen if 2 are not both standing on their own. Brown\(^3\) shares through her Acompañar theory that truly accompanying the client requires building trusting relationships, using good assessment skills, and honoring self-determination.

Brown’s theory called Acompañar, which translated from Spanish means “to accompany,” emerged from her grounded theory research. The implications of Acompañar, as well as her subsequent research based on shame resilience, vulnerability, authenticity, and empathy, are practically useful for NPs to create effective and meaningful partnerships with patients. Brown’s work describes Acompañar as “effectively sharing your knowledge and resources while honoring the fact that it is their journey, not yours.”\(^3\)(p28)

Acompañar is based on the concept of creating meaningful and “effective helping” partnerships with clients.\(^3\)(p71) Acompañar encourages the patient/client to be an expert in their life. Brown associates this with “effective helping” and is at the core of “accompanying the client.” This notion is congruent with cultural safety and Empathetic Partnership. This will hopefully impact the power relationship dynamics between the client and NP.

Part of the Acompañar theory requires mutual vulnerability of both helping professional and client/patient. Shifting from a position of power to partnership and including accompaniment and mutual vulnerability are essential to practicing both cultural safety and empathetic partnership. This requires reflection from the NP, as described earlier; a shift in attitude and practice; and a willingness to become novice. This allows the patient to step out of the shoes of a novice and show that they are an expert regarding their culture and the needs and desires they have around the health care experience. When an NP practices empathetic partnership by using the 6 key elements described to create a relationship of accompaniment, the traditional power dynamic dissolves and creates a space for an effective partnership to develop, which is at the heart of holistic care and cultural safety. The partnership between an NP and a client will look different because each patient’s needs are varied and individualized.

However, partnership is based on the NP being open to the health care interactions and subsequent client/NP relationship being based on the core needs and desires of the client. This is in contrast to the needs of the NP or what the NP may feel the client needs. Partnership requires the NP to ask nonjudgmental questions, remain open, and encourage and support the client as they experience and live their own journey.

Cunico et al\(^34\) state, “Empathising means understanding, sharing and creating an internal space to accept the other person, hence helping them to feel understood and not alone.”\(^3\)(p2016)

Cunico et al published a study in 2012 regarding teaching and developing empathy in nursing students. In the study, empathy is highlighted as a “major component of the relationship between patient and nurse and is an observable and teachable skill that nurses are requested to process.”\(^34\)(p2017) However, the study suggests that there are multiple definitions of empathy and multiple ways to measure it. Citing many references, the study concludes that empathy can be developed and taught. This highlights the need for both nursing students and practicing nurses and NPs to be involved in empathetic training as part of the Empathetic Partnership framework.

Brown\(^3\) agrees that empathy can be taught. Brown’s definition of empathy is “the skill or ability to tap into our own experiences in order to connect with an experience someone is relating to us.”\(^3\)(p33)

Brown states, “In order to be empathetic, we must
be willing to recognize and acknowledge our own lens and attempt to see the situation that someone is experiencing through her lens.** Brown references Wiseman, a nursing scholar, in her own work on empathy. Wiseman conducted a concept analysis on empathy and concludes that “self-awareness… is a prerequisite to empathy.”  

Wiseman states the defining attributes of empathy are to see the world as others see it, to be nonjudgmental, to be able to understand another’s feelings, and to communicate the understanding.4,55 Studies have shown that empathy from health care providers is associated with better health outcomes for patients.36,37 This illustrates that empathy from health care providers is not only useful for empathetic partnerships but also is clinically relevant for improvement in statistical, measurable patient outcomes.

**CONCLUSION**

It is the responsibility of the NP, and all health care providers, to create a safe and welcoming health care experience for diverse populations.38 NP's may often be in positions to affect positive change through leadership, advocacy, and sharing of knowledge with those in their lives.39 Individuals in the WSW population, as well as all patients, deserve to be treated in a way that makes them feel safe so they have an opportunity for a partnership with their health care provider if they so wish. The Empathetic Partnership framework aims to provide this opportunity for every patient. Empathetic Partnership provides a practice framework for NPs to provide holistic care and create effective therapeutic partnerships with patients. This framework is useful for clinical practice because it provides 6 key elements to guide both novices and experts in how to create and maintain effective and therapeutic partnerships. Nursing cultural safety—“walking alongside”—and sociologist Brown’s “accompanying” theory suggest interdisciplinary synthesis because they share the same ultimate goal of effective, therapeutic, and safe helping partnerships between the NP and the patient. The interdisciplinary aspect of Empathetic Partnership invites conceptual inclusivity. It validates the nursing profession’s cultural safety concepts and further helps to inform NPs and all helping professionals about how to create these partnerships more effectively. Using the Empathetic Partnership framework in practice provides the opportunity of inclusion, acceptance, and the development of partnerships between clients and NPs to pave the way to optimal therapeutic relationships.

**References**


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http://dx.doi.org/10.1016/j.nurpra.2014.04.009