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Patience in Nursing: A Concept Analysis

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Abstract:

Patience is widely acknowledged as an essential professional quality in nursing practice, yet it has received strikingly little systematic theoretical attention within the discipline. Despite frequent invocation in nursing education and professional discourse, the concept lacks a precise, standardised definition and a coherent conceptual framework that would enable its integration into curricula, clinical evaluation, and research. The study examined the meaning of patience in nursing, delineate its defining attributes, distinguish it from related constructs, and identify its antecedents, consequences, and empirical referents through structured concept analysis. Walker and Avant's (2019) eight-step method of concept analysis was applied, drawing on peer-reviewed literature from nursing, psychology, philosophy, and health sciences retrieved from PubMed, CINAHL, PsycINFO, and Scopus. Six defining attributes of patience in nursing were identified: tolerance of delay without resentment, emotional stability and regulation, acceptance of uncertainty, persistent but non-coercive engagement, empathic awareness, and intentional self-control. Antecedents encompass challenging clinical circumstances, cognitive recognition of the need for patience, adequate psychological resources, and supportive professional environments. Consequences include strengthened therapeutic relationships, improved patient adherence, enhanced patient satisfaction, and professional fulfilment. Unsupported patience may contribute to compassion fatigue, burnout, and delayed clinical decision-making. Reconceptualising patience as a professional competency rather than merely an innate personal trait provides a stronger foundation for its integration into nursing education, leadership development, and clinical research. Strengthening patience may improve patient-centred care outcomes and reinforce the therapeutic nurse-patient relationship.

Keywords: patience, nursing theory, therapeutic relationship, emotional regulation, Walker and Avant, professional competency,

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Introduction

Some skills in nursing are obvious, and are the ones that are taught and tested deliberately, these are clinical skills, diagnostic reasoning and accuracy of technical procedures. Other skills are not as obvious but just as potent when it comes to the quality of care that is delivered and the longevity of the therapeutic nurse-client bond. One such attribute is patience. Patience is widely thought to be an important attribute of a good nurse, but has been virtually ignored as a theoretical concept on its own within nursing science. Although nurses are regularly encouraged to be patient with patients, families, students and interprofessional colleagues, references to what it means to be patient in clinical settings are rarely given in nursing curricula or theories (Walker & Avant, 2019).

Patience, in common speech, generally means to endure delay, inconvenience, and/or difficulty without getting irritated or upset. In a medical setting, however, patience is a much more significant attitude. It involves ongoing therapeutic interaction, intentional management of emotions, and staying focused on and tuned into patient needs when situations in the clinical environment are uncertain, repetitive and/or emotionally demanding (Halldorsdottir, 2008; Schnitker, 2012; Gross, 2015). Nurses are constantly faced with patients in pain, fearful, confused, cognitively impaired and existentially distressed. These encounters can be effective only if the nurse maintains a calm, supportive and empathic demeanour over a long and unpredictable time period, which is the basis of the relational concept of nursing care as conceptualised in foundational nursing theories (Peplau, 1991; Watson, 2008; Travelbee, 1971).

There has been a significant amount of theoretical work in the nursing profession about caring, empathy, compassion and therapeutic communication (Watson, 2008; Boykin & Schoenhofer, 2018; Swanson, 1991). But, unlike in the professional discourse, patience has not been the subject of similar conceptual enquiry. This gap has real-world implications; without a clear definition of key concepts, it is difficult to integrate these concepts into education, assess them in clinical practice or systematically study them (Walker & Avant, 2019; McEwen & Wills, 2019). There was a lack of a clear conceptual framework so that there is no clear theoretical framework for building training programmes for such competency for nurse educators and there are also no tools for clinical leaders to assess and/or support this competency in their teams.

The modern healthcare systems make it challenging for nurses to be patient. Raised levels of patient acuity, low staffing levels, time compression, and the emotional nature of caring for more complex patients have resulted in an increase in occupational stress, compassion fatigue and burnout among the nursing population worldwide (Dall'Ora et al., 2020; Gustafsson & Hemberg, 2022). In such settings, patience is not only more difficult, it is more important to the patient's well-being to bring compassionate and person centred care. Moral distress, the psychological distress that is experienced when the nurse is unable to act in line with their moral obligations, is a direct concern in relation to the loss of patience in the midst of long-term work-related distress (Gallagher, 2011). This paper is a concept analysis of the concept of patience in nursing based on Walker and Avant's (2019) eight-step framework to clarify the meaning, establish the defining attributes, describe the field and non-field examples, clarify the concept's boundaries, resolve conflicting cases, define the concept's antecedents, and explore its implications for nursing education, research, and practice.

Selection of the Concept and Purpose of Analysis

The concept selected for this analysis is patience. Its selection was motivated by the observation that patience is one of the most frequently invoked yet least theoretically elaborated professional qualities in nursing. Nursing students are routinely instructed to demonstrate patience in clinical placements, and professional nursing standards consistently list patience among expected competencies, yet the concept is rarely defined with sufficient precision to enable its systematic development or assessment (White et al., 2021). This gap between frequency of use and theoretical clarity makes patience an appropriate and important subject for concept analysis.

The purposes of this analysis are fourfold. First, it aims to establish a precise conceptual definition of patience grounded in the nursing context and applicable across diverse clinical settings. Second, it seeks to distinguish patience from closely related constructs including tolerance, perseverance, acceptance, resilience, and passivity which share conceptual overlap but represent distinct psychological and behavioural processes. Third, the analysis aims to identify empirical referents that enable patience to be measured, taught, and evaluated in clinical practice and research. Fourth, it addresses professional sustainability: understanding the conditions that support and deplete patience is essential to preventing the compassion fatigue and burnout that result when patience is demanded without adequate organisational support (Maslach & Leiter, 2016; Delgado, 2017). Together, these purposes position the analysis as both a theoretical contribution to nursing science and a practical resource for nursing education and healthcare leadership.

Method

Walker and Avant's (2019) eight-step method of concept analysis was employed for this study. This method is among the most widely applied frameworks for concept analysis in nursing science and is particularly appropriate for clarifying concepts that are frequently invoked but lack precise theoretical definition. The eight sequential steps are: selection of the concept; determination of the aims or purposes of analysis; identification of all uses of the concept; determination of defining attributes; construction of a model case; construction of borderline, related, and contrary cases; identification of antecedents and consequences; and definition of empirical referents (McEwen & Wills, 2019).

A systematic literature search was conducted across PubMed/MEDLINE, CINAHL, PsycINFO, and Scopus. Search terms included: patience, emotional self-regulation nursing, therapeutic nurse-patient relationship, tolerance nursing, clinical communication, empathy nursing, concept analysis nursing, and professional virtue healthcare. No lower date restriction was applied to ensure capture of foundational philosophical and theoretical works, with empirical evidence drawn primarily from publications between 2000 and 2024. Source disciplines included nursing science, psychology, positive psychology, moral philosophy, health communication, and educational theory. Reference lists were hand-searched for additional sources, and synthesis proceeded inductively through iterative thematic review.

Uses of the Concept Across Disciplines

Etymological and Dictionary Foundations

The English word patience is from the Latin word patientia and Latin pati means suffer or endure. This etymological background reinforces the connection of the concept with passive ‘suffering', which is also evident in the common dictionary definitions of patience as ‘the quality or state of being patient' or ‘the capacity to endure without complaint', to ‘bear

calmly', or 'to be tolerant of or indulgent towards others'. This reflects one aspect of the concept, but it does not exhaustively describe patience in professional healthcare settings as it is not a passive form of patience, but one that is active, intentional and relational (Schnitker, 2012). Passive connotation of the word suggests a passive attitude, whereas in clinical nursing practice, patience is a purposeful engagement, an emotional regulation and a caring attention of empathic care.

Philosophical Perspectives

The philosophical traditions provide a much more extensive description. In the Stoic tradition, patience was equated with inner discipline, the ability to have an even temper and rational calmness in situations which are not under our control. This is applicable to nursing in that situations of uncertainty, uncontrollable patient outcomes and system pressures are common occurrences that require nurses to maintain a professional demeanor to deal with them. The virtue of patience was put into the context of moral virtues, and was defined as the middle ground between being too quick-tempered and passive, according to Aristotle. From a theoretical perspective, this is important for nursing as a nurse who can tolerate anything without setting boundaries is not being patient, but rather compliant and may ultimately negatively impact patient care and their own well-being. True patience involves the knowledgeable judgment to know when to be patient and tolerant and when to take action, a form of discriminative competency that is a part of clinical skill (Benner, 2001). Patience has also been taught as a virtue related to perseverance, hope and a compassionate presence to those who suffer in the context of palliative, oncological, and mental health care, which are all themes related to the relational and existential aspects of nursing (Koloroutis, 2004).

Psychological Conceptualisations

The most empirically developed account of patience is from the contemporary literary field of psychology. Schnitker's (2012) basic study was instrumental in the foundational study of the positive psychological trait of patience and its relationship with better well-being, less negative affect and better interpersonal relationships. Importantly, Schnitker 2012 differentiated three types of patient behaviours: interpersonal patience in interpersonal relationships, most relevant to therapeutic encounters in nursing; daily hassles patient behaviours – when dealing with everyday frustrations and practical difficulties; and life hardship patient behaviours – when faced with a major adversity or chronic difficulties. In nursing, there are three types of patience that are regularly called for: interpersonal patience in therapeutic relationships with patients and families; daily hassles patience when faced with systemic challenges and documentations requirements; and life hardship patience when constantly caring for patients with progressive or terminal illnesses. Longitudinally, Schnitker et al. (2017) showed that patience can be developed by repeated emotional regulation experiences over the lifetime, and thus can be taught as a competency in nursing education.

Gross's (2015) process model of emotion regulation is an important theoretical addition which outlines cognitive reappraisal and response modulation as regulatory processes by which dispositional patience is put into action behaviourally. The research on delayed gratification and self-control (Mischel, 2014) also demonstrates that this tendency to delay one's immediate reactive impulses in order to attain longer-term goals, such as relationships and clinical care, is learnable and measurable, and is the basis for interventions focused on patience in educational environments in nursing.

Patience in Nursing Practice

In nursing, patience can be expressed in a wide range of clinical settings, with each setting having a unique arrangement of the processes of patience. When nurses need to repeat instructions and encouragement over a number of contacts to achieve understanding and/or behaviour change, patience is needed when educating patients. This was placed in the context of patient centred communication, in which Epstein and Street (2011) suggested that true person centredness involves taking care in the timing of education and learning interactions with a patient, based on their readiness rather than the time frame of the nurse. Patient, in mental health nursing, is a fundamental aspect of therapy, as the building of trust with a seriously mentally ill patient is an inherently slow one, and it takes patience and a non-pressuring approach to be successful, it may take long periods of time (Travelbee, 1971; Peplau, 1991). Patience is important in palliative and hospice care where patients are knowing that they will die, and do not require or want clinical intervention, but want to be cared for by human beings, as patients experience a profound existential suffering (Koloroutis, 2004; Leininger, 2006). As a paediatric nurse, patience involves adaptive communication that is sensitive to the developmental level of the child and the family situation, and takes into account periods of non-linear growth and change without being frustrated (Benner, 2001). In all settings, patience is the relational backbone that other nursing therapeutic skills (clinical assessment, health education, emotional support, and care coordination) are effective tools of.

Defining Attributes

Defining attributes consist of an array of attributes that are shared across literature and are essential and sufficient in order to correctly identify the concept (Walker & Avant, 2019). Patients in nursing are characterized by 6 attributes which were derived by iterative synthesis.

Tolerance of Delay Without Resentment

The first and most basic one is the ability to wait for someone or something with patience, and not to feel frustrated, hostile or resentful towards the person or the situation for which the delay exists. In nursing it has a very special meaning: the nurse's tolerance ought not to be simply a repression of her own frustration, but rather a sign of her acceptance and unwrushedness towards the patient. This quality was called forth by Halldorsdottir (2008) as one of the characteristics that distinguishes the caring nurse-patient encounter: whereas a tolerant, unhurried nurse gives her patient a sense of spaciousness in her encounter with the patient, an impatient nurse communicates her lack of patience by treating the patient as a burden. The clinical implications are real when patients feel their nurse is tolerant of the patient's rhythm, they often feel more satisfied, are more willing to share with their nurse, and have a stronger therapeutic relationship (Epstein & Street, 2011).

Emotional Stability and Regulation

The second thing is the conscious and conscious control of one's own emotions to keep them stable, calm and therapeutically present when dealing with challenging or frustrating clinical situations. This includes using Gross's (2015) emotion regulation strategies including cognitive reappraisal to reframe problematic patient behaviours in ways that remove reactive behaviours. Emotional regulation for patience is the nurse who feels frustrated to have the call bell pressed again and again by a confused patient, but who consciously reappraises the situation as a manifestation of the patient's distress. This is a type of deliberate emotional

management which Benner et al (2010) identified as a characteristic of expert nursing practice, with expert nurses having more complex abilities to stay calm in challenging situations. What is important to note is that, unlike emotional suppression, when emotions are reappraised and controlled they are associated with resilience and professional fulfilment (Jackson et al., 2007; Gross, 2015); however, if this reappraisal is not followed by actual control, the emotional suppression without regulation ultimately causes psychological exhaustion and burnout.

Acceptance of Uncertainty

The third one is the ability to work effectively and maintain therapeutic involvement despite incomplete information, fuzzy clinical scenarios and uncertain outcomes. Uncertainty in healthcare is all-pervasive, that is, diagnostic, prognostic and therapeutic. Patience helps to allow nurses to accept this uncertainty without prematurely closing off the inquiry, or sharing any anxiety with patients that might increase their own. According to Benner et al. (2010), one of the developmental levels of nursing expertise is the ability to tolerate the uncertainty that is part of doing nursing, not as a personal or system failure. This attribute is located in the capacity of the nurse to hold space for the patients' own temporal and rate of adjustment, as per Reed's (2018) self-transcendence theory. The nurse's role as a witness to patients' experience is specifically mentioned in Parse's (2014) human becoming paradigm, and the nature of this role is directly theorised as a competency of the nurse.

Persistent but Non-Coercive Engagement

The fourth attribute embodies the active and purposive aspect of patience which makes it to be different from passivity. Patience is the ability to engage patients in therapeutic interactions over time, or to continue to educate patients when they do not initially respond, be present for patients when they pull away from therapy, and do nursing assessments when they are not showing progress. The critical word is non-coercion: This persistence does not involve pressuring, manipulating or overwhelming patients, but it means to be steadfastly available in the therapeutic setting and to let patients respond at their own rate (Swanson, 1991; Watson, 2008). According to Swanson's (1991) theory of caring, this is seen as 'doing for' when working on behalf of the patient, but also preserving their dignity, and 'being with' being emotionally present without imposing on the patient and maintaining a sense of ongoing concern. From a theoretical perspective, the difference between perseverance and patience lies in the difference between being goal-focused and internally-focused and relationally-focused and responsive to the readiness and experience of the patient.

Empathic Awareness

The fifth defining characteristic is actively seeking to understand and remember the patient's subjective experience, their emotional state, fears, values, cultural context and perspective on their illness, as a motivational resource, which will sustain patient and compassionate engagement. Empathic awareness can enhance patience through a relational anchor – when the patient's behaviour is irritating it is possible to change the perspective of the behaviour to that of the patient's experience rather than a personal imposition. In a literature review examining the link between empathy development and communication in nursing education, Brunero et al (2010) reported that an empathetic approach was always linked to more tolerant communication styles with patients and to a decrease in aversive interpersonal reactions to patient's challenging behaviours. In the transpersonal caring relationship, Watson's (2008) theory of human caring places empathic understanding as a key element in

caring, suggesting that in order to care one needs to be attuned to the patient's world view. This is expanded by Leininger's (2006) culture care theory that takes into account cross cultural interactions when caring for patients, requiring patience in the face of cultural differences where those differences relate to health beliefs or communication styles, and an attitude of curiosity and respect for the patient's culture.

Intentional Self-Control

The sixth attribute is the conscious and thoughtfulness control of behaviour responses to promote behaviour in line with therapeutic objectives instead of short-term emotional urges. This includes not interrupting the patient, speaking in a calming tone of voice, having an open body language, taking a pause to consider the patient's perspective and responding to prevent reactive communication, and being mindful of the pacing of clinical communication to the patient's ability and not the nurse's schedule (Gross, 2015; Benner, 2001). Schnitker (2012) has shown empirically that dispositional patience is manifested in behaviours that are acted upon in the clinical setting (intentional self-control) and that these behaviours can be trained through deliberate practice and that they can be measured through a behavioural observation. This is a deliberate regulatory aspect, one that fits into Benner's (2001) idea of practical wisdom, the expert practitioner's ability to act in a wide and sometimes unpredictable range of clinical scenarios, and that self-controlled patience is a part of clinical expertise, not some sort of side issue in the realm of interpersonal skills. As Maslach and Leiter (2016) said, deliberate cognitive effort that accompanies ongoing self-control is a finite resource that can be depleted through a series of work demands, so it's not nursing staff's job to be patient.

Model, Borderline, Related, and Contrary Cases

Model Case

In a model case, all the attributes of the case are shown in one complete scenario (Walker & Avant, 2019). A community health nurse is giving home care to a 72-year-old male with uncontrolled type 2 diabetes mellitus (DM2), who has recently bereaved his wife of 47 years. On initial visits, the patient is only minimally interested in making lifestyle changes, avoids taking medications, and is frequently tearful and emotionally withdrawn, saying that there is little reason to take care of his health. Instead of continuing with health education and asking the man to do something, the nurse aims to provide a relational, safe, non-rushed, environment in which she hears his grief, his story of his life with his deceased wife, without introducing health education concepts (Watson, 2008). The nurse engages the patient in appropriate health goals in a gradual way, starting with what he wants to do—going to his grandchildren's school events—and over weeks he is able to do more and more. The nurse also links him with bereavement support in his faith community. During this time the nurse is always calm and accepting even though there is no instant clinical improvement, doesn't sound urgent or disappointed and mentally views each challenging visit as a therapeutic help and not a clinical failure (Halldorsdottir, 2008; Schnitker, 2012). After the 6th week, the patient is now self monitoring his blood glucose and says to the nurse that the highlight of the week is her visits. This situation illustrates all six attributes: being tolerant of delays without resentment (non-pressuring engagement); remaining emotionally stable (maintaining composure during the tough times), not assuming the patient is ready to change (non-pressuring engagement), engaging persistently, but not coercively (continued therapeutic

presence); being aware of the grief context in which resistance exists (empathic awareness); and exercising deliberate self-control (intentional pacing based on patient's emotional state).

Borderline Case

Borderline' has some but not all of the characteristics (Walker & Avant, 2019). A ward nurse gives a busy morning round to an elderly patient, allowing the patient time to finish talking before the nurse starts her assessment. She doesn't cut in and show signs of frustration. But, her body language is distracting: She keeps looking at her watch, she is standing not sitting at the bedside, and she responds in short stereotypical sentences that aren't really listening. She shows some tolerance of delay (in a narrow behaviour sense) but not empirical awareness, intention to use self-control for therapeutic presence, or sustained, engaged attention. Subsequent to this, the patient says that the nurse was too busy to listen or lacked interest in really listening, although, technically, the nurse had to wait. The difference between surface (behavioural) and substantive patient-centredness can be seen in this case example, where only the first 6 attributes are followed. The positive consequences of the concept – the therapeutic relational outcomes – are not achieved through mere surface level patience, but with emotional involvement (Epstein & Street, 2011).

Related Case

A related case has some commonalities but significant differences of mechanism (Walker & Avant, 2019). A clinical nurse educator who has been supervising a student's medication calculation competency for 5 consecutive sessions will not allow the student to move on with clinical placement until she or he develops competency in this skill, even though there is pressure to move the student through the clinical placement process. This shows perseverance, being persistent and purposeful in goal-directed tasks in the face of possible obstacles, without the relational, empathic and emotionally regulating aspects that are part of patience. Perseverance is self-focused on how to reach a goal and relatively unaffected by the other party's speed or emotional experience, while patience occurs when the other party's emotional experience is known, and the interaction is done in a non-coercive manner that respects the other party's autonomy (Schnitker, 2012; Schnitker et al., 2017). A nurse who is persevering will continue to strive for a clinical objective despite the patient's readiness, while a patient nurse will adjust his/her persistence according to patient's emotional state and expressed needs. Somewhere between the two lies an area that is clinically significant if perseverance without patience leads to coercive or paternalistic relationships that detract from patient autonomy.

Contrary Case

A contrary case, which illustrates the lack of all the characteristics (Walker & Avant, 2019). Orientee nurse has the same error on medication administration log on her second shift, it is noticed by a charge nurse. The orientee is not given the chance to come back from her patient room and have the charge nurse correct the paperwork, but instead she does it, and when the orientee comes back she tells her “the paperwork was done the wrong way and I expect better of you by now.” The orientee appears “upset” and more and more avoids the charge nurse for the rest of the shift. This situation clearly illustrates impatience in all its clinical consequences: No tolerance of delay - the error provokes immediate unilateral action; No emotional regulation - frustration drives reactive communication; No acceptance of uncertainty about where the orientee is going in his/her learning path - the action is unilateral and coarse; No non-coercive approach - the communication is coarse and coercive;

No empathic awareness of what the orientee needs to learn and how he or she is feeling - the communication is reactive; and No intentional self-control - the communication is reactive rather than deliberate (Jackson et al., 2007). The distress and avoidance of the orientee demonstrates direct effects of impatience in clinical and educational settings, on the relationship and in the workplace.

Antecedents and Consequences

Antecedents

Antecedents refer to conditions that have to be met for the concept to happen (Walker & Avant, 2019). There were five antecedents of patience in nursing. The first is when the clinical situation is challenging, requiring the nurse to stretch her emotional and cognitive resources; such situations include a patient encounter that is resistant, repetitive, ambiguous, slow with progress, or emotionally demanding. If there is no challenge there is no need for patience: it is the challenge event that triggers patience as a professional response, as noted by Dall'Ora et al., 2020 and Benner, 2001. The second antecedent is the nurse's metacognitive awareness that the patient's circumstances require patience, which prevents her from reacting or rushing into action clinically. This recognition is part of the professional expertise itself, with Benner (2001) proposing a novice to expert continuum in which expert nurses have increased situational assessment skills that lead to adaptive responses as opposed to reactive responses.

The third antecedent is having sufficient psychological capacities in the nurse; emotional regulation capacity, cognitive flexibility, residual compassion satisfaction, and physical and emotional recovery from previous demands. Gross (2015) showed that emotion regulation is a limited resource meaning that a nurse who had used a lot of emotional resources in previous regulatory demands may not have the resources to use when they are needed later, such as when the nurse is patient during interactions with other people. This directly relates to workload management and shift design (Dall'Ora et al., 2020). The fourth antecedent is a supportive professional environment that is characterised by an organisational culture which values relational care; time for therapeutic interactions; recognition of the emotional work of nursing; and opportunities for peer support and reflective practice (American Nurses Association, 2023; Gallagher, 2011). The structure of nursing care limits the opportunities for the functioning of patience for those who care under conditions of chronic time pressure, without the support of relationships. Fifth antecedent is the nurse's internalized professional commitment to the values of therapeutic relationship and person-centred care, in which believing in the clinical importance of taking time to interact at the pace of the patient is important (Peplau, 1991; Watson, 2008). The motivational basis for the cognitive and emotional work to be done in order to be patient under pressure is lacking if there is not a values foundation.

Consequences

Consequences are the outcome(s) that follow the happening of the concept (Walker & Avant, 2019). Patience's benefits are at the relational, clinical and professional levels. The main positive effect at the relational level is the improvement of the relation between the therapist and patients. In her study, Halldorsdottir (2008) found that patients always said that nurses who were unhurried, tolerant and empathically present created genuine caring encounters, and that the quality of the relationships in the encounters affected patients' feeling of safety, trust and willingness to give the nurse important information, which is necessary in order to

provide good care. This was theorised by Watson (2008) as the formation of transpersonal caring which is a relational quality that facilitates healing that goes beyond the biological. Travelbee (1971) also suggested that the nurse-patient relationship can only grow through the ongoing interaction of the patient and the nurse; respecting the uniqueness of the patient's experience.

The second positive consequence is an improved adherence to treatment by the patients. In a systematic review of the patient-centred communication research, Epstein and Street (2011) found that patients who perceived their healthcare provider as being unhurried and truly involved experienced a much higher medication adherence, appointment attendance and health behaviour modification. The third consequence is increased patient satisfaction, and patient satisfaction is related to the ability of providers to be patient and attentive in clinical settings, among other factors (White et al., 2021). Professionally, Lavelock et al. (2019) found a positive correlation between professional fulfilment and the sense of meaning experienced by helping professionals and attributed this to the relational rewards of the practice of patience, which in turn fuels a sense of fulfilment and meaning. But, when patience is required and not supported by the organisation or distorted into a passive acceptance of negative situations, it can lead to compassion fatigue or burnout (Maslach & Leiter, 2016; Delgado, 2017; Gustafsson & Hemberg, 2022). Gallagher (2011) found that a possible result of the practice of patience is moral distress in the face of passive tolerance of poor care. The notion of patiently waiting for something that does not happen can also be a form of avoidance of the need for assertiveness and may result in missed clinical interventions, there is an Aristotelian insight that there is a discriminative wisdom in patiently waiting for something that does not happen; namely, when it is appropriate to be patient and when it is not (Benner et al., 2010).

Empirical Referents

Empirical referents are observable phenomena or measurable categories that illustrate the defining features of the concept, and allow it to be observed and identified, evaluated, and investigated in the real world (Walker & Avant, 2019). Four types of empirical referents of patience in nursing were found. The first includes behaviours in clinical communication that are visible, including giving opportunity to patients to complete their spoken versions without interruption; keeping a calm tone in voice and body language when dealing with the emotional challenges of patients; repeating explanations without expressing irritation; sitting at the patient's bed side not standing beside the door during patient conversations; and tolerating silence without immediately filling it with directives, (Travelbee, 1971; Gross, 2015; Benner, 2001). These behaviours can be directly observed in the clinical environment and can be assessed using structured behavioural observation instruments, standardised patient scenarios, video-based communication analysis (White et al., 2021; Sitzman & Watson, 2013).

The second are self-report instruments that are validated. Schnitker's (2012) Three-Factor Patience Scale is composed of separate subscales that measure interpersonal, daily hassles, and life hardship domains of patience, and has construct validity that allows researchers and educators to measure dispositional patience in nurses, monitor for changes post educational interventions, and explore the relationship between patient and professional outcomes such as burnout, compassion satisfaction, and quality of therapeutic relationships. In nursing education, there is a need to measure the moral and motivational aspects of patience, as well

as its regulatory aspects, and Schnitker et al. (2017) have developed the Patience Virtue Scale to do just that. Patient-reported experience data (PRE) is the third referent category. Instruments to measure patient satisfaction typically have questions that measure whether the nurse took enough time, did not seem in a hurry or impatient to listen, and communicated without showing impatience. Epstein and Street (2011) proved patient-reported communication quality is a valid proxy for relational aspects of care that are facilitated by patience. The fourth referent category is performance assessment in simulated and real clinical environments – objective structured clinical examination stations, standardised patient examinations with simulated interactions and placement mentor assessments targeting communication and relational skills that are linked to the expression of patient skills such as patience are examples of direct assessments of patients' expression of patience in nursing students and qualified practitioners (White et al., 2021; Larrabee, 2009).

Discussion

The concept analysis results in a conceptally distinct multi-dimensional professional competency of nursing, which is distinguished from related concepts by six attributes, and only if they occur together, are these attributes sufficient for identifying the concept. There are a number of themes that warrant a more general discussion for their implications for nursing education, practice and research.

The most basic theoretical contribution of this analysis is the shift of understanding patience as a personal trait into a trainable professional competency which can be developed in a structured educational process, supported by organisational design and measured with valid empirical methods. The evidence from the above studies (Schnitker et al., 2017; Gross, 2015; and Benner et al., 2010) all point to the developmental plasticity of these component processes of patience. The implications of this reconceptualisation for nursing education programmes are as follows: If patience is a competency and not a trait, it must be included in the curricula of nursing education, be a specific target of educational strategies – such as mindfulness training, reflective practice, emotion regulation skill building – and be measured by the empirical referents identified in this analysis rather than inferred from the dispositional characteristics of students.

Antecedent analysis shows the importance of the organisational conditions as necessary or blocking for the expression of patience in clinical practice. Since the three factors (adequate psychological resources, adequate time and supportive work environment) are not only facilitators of patience, but also its antecedents, it implies that healthcare organisations have a structural responsibility for the presence of patience. According to Dall'Ora et al. (2020) and Gustafsson and Hemberg (2022), there has been a rise in health care system burnout, which is actively eroding the psychological resources which patienthood relies on. So, when a healthcare leader asks a nurse to be patient, but doesn't solve these underlying structural problems, the leader is asking the nurse to be patient for something that doesn't have the necessary conditions. Appropriate staffing, protected time for therapeutic interaction and organised emotional support programmes should be regarded as investment in the conditions that enable patient-centred care, not as peripheral staff welfare and development opportunities.

The dual consequence structure detected that patience can lead to positive therapeutic outcomes, and under unsupported conditions to burnout and moral distress mirrors the overall trend found in the compassion fatigue literature with regard to the costs and benefits

of continuing empathic engagement (Maslach & Leiter, 2016; Gustafsson & Hemberg, 2022). Educational programmes for enhancing patients' understanding of their rights and the importance of waiting should thus be coupled with organisational initiatives to tackle the structural antecedents, such as workload equity, peer support, cultures of reflective practice, to ensure that the competency is matched by organisational capacity to sustain it throughout the nursing career.

Conclusions

Through this concept analysis, patience is found to be a multi-dimensional professional competency in nursing that is more than simply tolerating inconvenience. These six aspects of the therapeutic nurse-patient relationship are all summed up by the term tolerance, and the combined aspects are a relational, cognitive and affective competency that is essential to the quality of patient-centred care. Patience in nursing, as a construct identified in the analysis, is a professional competency that is manifested in deliberate and thoughtful actions of tolerating delay without resentment, being emotionally stable and regulated, accepting uncertainty, continuing to engage in therapy but without coercion, demonstrating empathic awareness of the patient's experience, and acting with intentional self-control for the benefit of the therapeutic relationship and the patient's autonomy, dignity and ability to engage with health.

The result is that reconceptualization of patience as a teachable, assessable, and researchable professional attribute allows for nursing education to provide a conceptual basis for designing targeted curricula, nursing leadership to create organizational conditions under which patience is sustainable, and nursing research to define and provide a conceptually precise foundation for exploring patient relationships with clinical outcomes and professional well-being. Future studies should focus on developing and validating instruments to assess nurse patience, developing effective training programmes to increase nurses' patience, such as mindfulness-based training, reflective practice, and emotion regulation skill training, longitudinal studies to investigate the relationships between nurse patience, the trajectory of burnout, and patient outcomes, and studies to examine the organisational moderators of nurse patience expression in clinical settings. Patient experience improvement through cultivation of patience as a nursing skill and a sustainable environment is a worthwhile investment in the quality, safety, and humanity of patient care.

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