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Exploring nurses' meaning and experiences of compassion: an international on-line survey involving fifteen countries.

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EXPLORING NURSES' MEANING AND EXPERIENCES OF COMPASSION: AN INTERNATIONAL ON-LINE SURVEY INVOLVING FIFTEEN COUNTRIES.

Abstract

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Implications for practice: Further research is needed to explore the country and culture differences in the enactment of compassion.

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Introduction

In recent years, there has been much attention to the fact that compassion in healthcare seems to have decreased, with alarming reports and media stories further raising this issue. Literature has emerged both in the United Kingdom and elsewhere, whilst discussion and debate surrounding the notion of compassion is evident globally. The aim of the current study was to explore similarities and differences in the understanding and experiences of

compassion in nursing across 15 countries. Only the qualitative data from the on-line survey are reported in this article. Participants were asked to respond the following questions:

1. How would you define the term compassion?
2. How is compassion demonstrated in practice? Please provide some examples.
3. Please offer any comments, advice, views, or stories which can shed light on the meaning and use of compassion by nurses in your country.

Literature Review

Compassion means 'to suffer with', from the Latin *com* (together with) and *pati* (to suffer) (Schantz, 2007). Compassion has its origins in religious ideologies (Armstrong, 2011; CAREIF, 2013; Straughair, 2012): it is a central focus of many spiritual and ethical traditions, from Buddhism to Confucianism to Christianity (Goetz, Keltner & Simon-Thomas, 2010).

The NHS Commissioning Board for England (2012, p. 13) defines compassion as follows: *"Compassion is how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care."*

Culturally competent compassion has been defined as *'a human quality of understanding the suffering of others and wanting to do something about it using culturally appropriate and acceptable nursing interventions which take into consideration both the patients' and the carers' cultural backgrounds as well as the context in which care is given'.* (Papadopoulos, 2011; Papadopoulos & Pezzella, 2015, p. 2).

The attributes of compassion are believed to include: a subjective experience that recognises suffering and vulnerability (Dewar, 2013); empathy (Schantz, 2007); respect and dignity (NHS Commissioning Board, 2012); attentiveness (van der Cingel, 2011); a desire to

alleviate suffering (Goetz et al., 2010; Schantz, 2007) and cultural competence (Papadopoulos 2011, Papadopoulos & Pezzella, 2015). Curtis (2013; 2014) suggests that whilst compassion is innate, it is subsequently learned through socialisation. Goetz et al. (2010) state that compassion is an 'other-orientated state' and is likely to be most intense in response to the suffering of individuals who are self- relevant for example, offspring, relatives, friends, partners, and so on. The development of compassion for strangers – such as that required to be given to patients- is not so certain.

In England, compassion has risen to prominence in media and policy circles following reports of unsatisfactory care of patients (Abraham, 2011; Department of Health, 2012; Francis 2013; The Patients Association, 2009). Such reports identified cruelty and neglect, unnecessary suffering, degrading and inhumane treatment (Straughair, 2012) of people with learning disabilities at Winterbourne View, and of mostly frail elderly patients and patients who were nearing death at Mid Staffordshire NHS Foundation Trust (Hehir, 2013). There is concern that modern nurse education does not equip nurses to deliver compassionate care (Price, 2013). In England, the focus on compassion is part of a wider drive to improve the quality of care(Cummings & Bennett ,2012).

Kim draws on her own experience of being a patient (in the United States of America) and contrasts health professionals who demonstrated efficiency and clinical expertise with those who demonstrated connectedness and understanding but not particularly extraordinary skills(Kim & Flaskerud, 2007). However, such polarised views are not always helpful, since compassion is a relational concept and thus cannot be considered within a vacuum.

Compassion is often discussed within the context of what 'good care' looks like, and much of the literature is about good nursing practice, for example, care that is '*safe and effective but also compassionate'* (Adamson & Dewar, 2011, p. 43).

The ways in which compassion functions – the reduction of suffering and the formation and maintenance of cooperative relationships – may vary across cultures. Kim and Flaskerud (2007) discuss similarities and differences in cultural expression of compassion, arguing that Western patients and nurses are more likely to say and acknowledge what they are feeling, providing an opening for the nurse to express compassion. In the East however, patients may not express their feelings openly to health professionals and a nurse's expression of feelings for them might be unwelcome in what is considered a professional, not a personal, relationship.

Methodology

The questions in this survey were based on published literature on compassion and on-line discussion forums and blogs concerning the concept of compassion. The aim of the survey was to investigate similarities and differences in the way in which compassion in nursing is understood and experienced in different countries. The survey consisted of both open ended and closed questions. Following the piloting of the questionnaire with South Korean nurses minor modifications were made to improve the clarity of the questions, and to capture the participants' ethnicity.

The lead researcher recruited at least two volunteer co-researchers from each of the participating countries listed below. The role of the co-researchers included the translation of the questionnaire into their own language followed by its back translation to assure the quality and accuracy of the translation. In addition co-researchers translated the participant invitation/information letter, as well as the collected qualitative data. The invitation letter informed potential participants of the aim of the survey, the name of the ethics committee/s which provided approval for the study and emphasised that their participation was

anonymous, confidential and voluntary. Web-based electronic survey software was used to collect data in each country.

As a consequence of globalisation, it is not possible to make many assumptions about the culture of respondents to this survey in relation to their country of residence and work. Hofstede, Hofstede and Minkov (2010) describe culture as *'the collective programming of the mind that distinguishes the members of one group or category of people from others'* (p. 6). Hofstede et al. further argue that nations should not be equated to societies, which are forms of social organisation, and in research on cultural similarities and differences, nationality should be used with care. Mobility of health professionals has resulted in multi-ethnic, multicultural workforces in many of the countries participating in this survey. For example, respondents from the United Kingdom (UK) described themselves as: Asian, Australian, Black Caribbean, British, Indian, Irish, Japanese-American. While regional, ethnic and religious cultures account for differences within nations, people with different cultural backgrounds may form a single group with a single identity, for example, a professional identity (Hofstede et al., 2010). Alternatively, survey respondents may speak from the viewpoint of *'the shared mental software of the people in an organisation'* – the organisational culture (Hofstede et al., 2010, p. 47).

Sample

A convenience sample was recruited. Participants were eligible to take part in the study if they were a qualified nurse, final year student nurse, nurse educator, or nurse manager. In total 1323 respondents from 15 countries participated, out of which 9.9% were final year nursing students, 45.4% were practicing qualified nurses, and 29.3% were lecturers/nurse educators or nurse managers. A small percentage (8%) of responders chose the "Other" category whilst 7.5% did not state their occupation (please refer to Table 1).

[Insert Table 1 here].

Data collection

Each researcher/co-ordinator distributed the questionnaire to their network of nurses. Participants completed the survey on-line. For participants who could not access the online survey, paper questionnaires were used.

Data analysis

The responses to the open-ended questions were collated and one of the co-researchers/co-ordinators from each country undertook the translation into English, whilst the second checked the translation for accuracy and meaning. All data were sent to the lead researcher for analysis. Braun and Clarke's (2006) framework for inductive thematic analysis was used to identify, analyse and report themes emerging from the qualitative data for each individual country and across the 15 countries. One researcher assigned initial descriptive codes, which were then grouped into emergent and superordinate themes and discussed with the research team.

Results

The data revealed a number of components and actions, many confirming a global appreciation of elements of compassion that are already recognised. The results reported in this article convey the impact of the two superordinate themes, those of 'socio-political structures' and the 'conscious and intentional nature of compassion'.

Problems of quality and safety exist in healthcare systems worldwide (Dixon-Woods et al., 2014). In the research reported here, there was evidence of nurses feeling constrained and influenced by socio-political structural issues that impact on the delivery of care. In spite of perceived constraints, there was widespread acknowledgement of the conscious and intentional nature of compassion such as spending time with patients and their families, even

'going the extra mile', often 'giving of oneself' and working over and above the contracted hours. This appears to bring huge intrinsic reward to nurses, as well as benefits to patients. The notion of 'being there' and 'presence' were widely evident across the data, indicating the role of forming close connections with patients in providing care with compassion. Considering the patient as a unique individual was also widely evident in the data and related to 'being with the patient and his/her family'. There was evidence of awareness of the need to consider patients' culture, religion, socio-economic status, and ability, with particular attention to those people who may be 'under-served' by healthcare systems. The role of the nurse as a 'defender' or 'advocate' was also evident in relation to the provision of compassionate care.

Superordinate theme 1: Socio-political structures

This theme highlights the strength of policy in shaping perceptions of compassion and the ability to practice with compassion. While there was similarity across countries in terms of feeling that compassionate care can be constrained by policies that aimed to contain the costs of delivering health services, there were some differences between countries in relation to actions and reactions to these perceived constraints. Aspects of the policy, infrastructure and societal struggles that influence perceptions of compassion were evident, for example, target-driven policies in the UK, legacy of lack of universal coverage in USA, conflict in Colombia, and austerity measures in Greece:

'I feel we need to focus less on targets, tick box exercises and league tables'. (UK)

'Acute care in the US is focused on efficiency with strict protocols for most nursing tasks. The administrative or financial pressures for efficiency have reduced the time nurses are able to spend with patients and families ... [these] *reduce nursing care to a checklist [off] tasks'.* (USA)

'Today as a result of cuts and reductions of the nursing staff, and ... the increased workload in public hospitals, the aim is to finish as soon as possible what you have to do, dedicating much less time to the patient, especially his psychological/mental needs'. (Greek speaking Cypriot)

'I would like to have time for a conversation with a patient and their family, showing compassion and support… but unfortunately it is impossible in the Polish healthcare system. A Polish nurse does a job of three nurses and hardly has time for doing doctors' orders and filling documents. Taking care of a patient and having contact with them are dreams which probably will never come true. Today, patients are not satisfied with the Polish healthcare system. When patients are discharged from a hospital, they are given some instructions [on] what to do next and they have to manage everything on their own. It is not that bad if a patient has a family and somebody can help them but if a patient does not have a family, what then?' (Poland)

'Shortage of staff in the current economic crisis has an impact on the values and behaviour of nurses'. (Greece)

Perhaps, the consequences of cost-cutting measures are best summed up by a respondent from Australia:

'The most precious gift a nurse can demonstrate in the health system today towards a patient in the use of compassion is 'time'. We do not have the time required in a typical busy ward to spend with patients… Then we go home and beat ourselves up because we feel guilty we did not get back to the patient who asked for a little bit of time for a chat or [to]hold their hand in a time of need'(Australia).

The above quotes demonstrate the desire of nurses to be free from the socio-political barriers to providing compassionate care. The findings are pleas to policy makers and organisation

leaders to place patients at the centre of the organisation, and nurture the development of caring cultures by valuing staff and patients.

Superordinate theme 2: The conscious and intentional nature of compassion

Despite the structural constraints which are seen as negative forces which prevent the provision of culturally competent compassion, the findings provide examples of how individual care givers are dealing with these challenges. Significantly, compassion was universally perceived as both conscious and intentional, for example:

'[Compassion is] *consciousness of others' suffering'* (Colombia).

This superordinate theme is made up of several components which evidence this assertion.

a)Investing time in the nurse-patient relationship

It was apparent that in some countries, nurses were making conscious efforts to rise above perceived constraints on their time to care and were engaging in voluntary activities in order to provide high quality care for their patients, particularly the most vulnerable. Spending time with patients was identified as a crucial component of compassionate practice, and often, finding that time is intentional:

'Nurses take time to do voluntary work in their community to provide and share their knowledge'. (USA)

'Public health nurses spend their careers doing their best to improve access to care for unserved, uninsured or under-served populations'. (USA)

And in Colombia, a country that is troubled by conflict, displacement and poverty, nurses respond to the needs of vulnerable people through invoking a sense of solidarity in the face of adversity:

'Solidarity in desire to help others in a state of suffering'. (Colombia)

'The presence of the nurse in critical situations – natural disasters, rape, war, homelessness'. (Colombia)

In response to natural disasters in Australia:

'Much compassion coming from nurses was seen at the time of recent natural disasters, such as bushfire and flood. Particularly the fires in rural Victoria and Queensland floods. Homes, property and lives were lost. Nurses worked for days and around the clock to provide psychosocial, physical, nutritional and other forms of support'. (Australia)

There were many statements that demonstrate the importance of spending time with patients:

'Giving the person a sense that their suffering is worthy of your time and that you do care for them'. (Australia)

'Time – so they know you are supporting them. The patient is never in any doubt that we walk the path with them even if the outcome is not good'. (UK)

'Compassion is when the nurse who is very overloaded with documentation writing, finds the time to come to a sick person, talk, listen'. (Czech Republic)

'Compassion is to devote the time and be right next to the patient and simply hold his hand when he/she is in pain'. (Greece)

b)Being there/presence

As well as spending time with patients, respondents alluded to the quality of the time spent with patients by referring to presence:

'You must be able to express compassion in the moment'. (Czech Republic)

'Be there – empathy. Listening ... Showing presence'. (Israel)

'Being present, holding someone's hand during a procedure, explaining what is going [on] and why. Being interested in the whole person. Recognizing important times'. (USA)

'You need to show your patients that you are there to help them when [they are] in a bad situation. (Turkish speaking Cypriots)

'Stepping into the shoes of people in care'. (Colombia)

'By presence of the nurse, by touch, by reflection, by silence'. (Czech Republic)

'Ensuring a sense of security and love, a sense of understanding, frequent presence, providing a contact with a close person and a spiritual guardian, holding a hand, listening, just being with a patient'. (Poland)

'Listening with empathy whatever the patient needs to tell, giving enough time ... helping them to feel a unique being to whom we pay our attention'. (Spain)

'We listen to the patient's complaints and problems. We try to help them but if we cannot we just listen to them…' (Hungary)

c) Going the extra mile

Compassionate intentional and conscious practice is also characterised by engaging in activities that may be viewed as over and above the usual role of the nurse, or '*going the extra mile'*(Australia).

'Do acts of benevolence that go beyond nursing'. (Italy)

'Extra time for a lonely patient, to show that you care'. (Norway)

'Going beyond what is required of us – getting involved'. (Spain)

'Walking the patient to their car instead of just giving them vague directions to navigate through a big hospital'. (USA)

'Compassion can be shown when a nurse takes something that is not necessarily within their functions to contribute to the patient's welfare, ...a nurse can make a phone call to ask for a specific situation as his mood, the transition between the clinic and home, or just to say hello,

maybe the nurse makes this action more as a human being than as professional, but the line that divides that border may be diffuse'. (Colombia)

'*Give care without expecting anything in return'* (Philippines)

A participant from Greece expresses the conscious intentionality of 'going the extra mile' thus:

'Unselfish giving: Contribution to institutions, hospitals, humanitarian organizations, assistant to the needy (a poor family or a stranger). (Greece)

d) Individuality/personalisation

Taking account of patients' individual characteristics such as age, socio-economic status, culture, and general individual preferences was believed to contribute to compassionate practice in the following ways:

'*Being non-judgemental – people react differently under stress depending on their history/background'.* (Australia)

'Understand that each patient's suffering is subjective and unique'. (Israel)

'[Giving care with]… *dignity and respect despite criminal records'.* (USA)

'[Compassion]…*requires cultural awareness'.* (Philippines)

"You need to show your patient that you respect them and their needs. You need to be polite and always have a smile on your face." (Turkish speaking Cypriots)

A participant from Italy provided an interesting story which illustrates how nurses can personalise compassion to meet the uniqueness of individual patients:

'*One day while serving in the ambulance … some of my colleagues were complaining and advising that the patient was a retired professor, and a really talkative person. I was not worried about it; I chatted pleasantly with the "professor", realizing how much you can learn*

from anyone, talkative or not, giving importance to the patient as a person, and not as an object to be brought to a hospital.' (Italy)

One respondent from Colombia described the practice of a group of indigenous people who arrived at the Accident & Emergency department without the requisite identification papers. This family did not see themselves as Colombians and so did not comply with the requirement to hold Colombian identification. The situation involved a child and social workers who saw the lack of identity papers as a form of abuse and were planning to take the child into care. The nurse used her knowledge of the indigenous people to persuade the family to comply with the requirement. Another example of individualised compassion is provided by a participant from Norway who is able to provide culturally competent compassion to a new group of citizens:

'I work with refugees and immigrants. Especially in the encounter with new citizens, it is important to show that you care, give care to those who have had so many experiences of loss and have to orient themselves in a new country'. (Norway)

e) Defending and advocacy

The notion of protection of vulnerable people that is perceived as central to compassionate practice was extended to intentionally defend and advocate on behalf of people in need. This was particularly prominent in Colombia.

'Nurse as the defender of the patient – non violation of human rights' (Colombia)

'Accompanying vulnerable people when their rights are violated' (Colombia)

'Facilitating access to services for disadvantaged people' (Colombia)

'Defend the patient's rights' (Turkey)

'*Listening [to] the patient and his/her family actively, understanding their problem, pain, love, anger, trying to understand, to make [them] feel that you will defend them in any situation….*' (Turkey)

Discussion

The ability to empathise with others and the capacity for compassion are defining characteristics of human beings (Chrousos, 2014; Seager, 2014). Caring relationships involve unique interactions between individuals which can be supported or undermined by environmental, cultural and systemic conditions (Seager, 2014).

Respondents in all countries participating in this research reported the effects of organisational pressures on time available for the provision of compassionate care. Claims that adequate care is not provided by nurses due to shortage of time have been in existence for some time. In 1994 McKivergin and Daubenmire wrote about the '*chaos of hospitalisation'*, the potential fragmentation of care as a consequence of *'rotating caregivers'* and *'increased caregiver demands'*, whereby desires to listen and 'be with' the patient gave way to demands to 'do to' patients . They also stated that *'… opportunities in which to be sensitive to patients' needs are often missed and depth of therapeutic interaction is passed over in lieu of completion of tasks'* (McKivergin &Daubenmire, 1994, p. 66). The findings of our study echo McKivergin and Daubenmire's claims from over 20 years ago. In spite of frequent media and professional attention, reports of poor care continue in England with accounts of unacceptable standards of care in some areas (Templeton, 2015), and levels of avoidable harm remaining high (Department of Health, 2015). While progress has been made in improving quality and safety, attention is now focusing on the need to foster and sustain compassion in care.

High levels of desire to provide high quality care in the English National Health Service have been found, but inconsistencies persist in the demonstration of quality (Dixon-Woods et al., 2014; Crawford, Brown & Kvarngarsnes, 2014). However, England is not alone in experiencing organisational crises in health care. The narratives of the respondents in the current study also point to organisational cultures that prioritise efficiency and making savings over high quality care.

Indeed, organisational culture is recognised as an important antecedent to compassionate practice in England: *'In many ways the Mid Staffordshire story was one of a weak board driven by national demands, creating a toxic culture in which meeting targets and balancing the books, not caring for patients, were the primary aim'* (Department of Health, 2015, p.15).

The current study suggests that some nurses are able to rise above organisational constraints and provide care with compassion. This appears to be achieved through the conscious and intentional nature of compassionate acts that recognise the importance of transcending the organisational culture in order to meet patients' needs. Some of the narratives provided by our participants also indicate that individualised compassion requires cultural knowledge and sensitivity. Bearing in mind the continuous migration of people across the globe and the rise of refugees and displaced people it is incumbent on nurse education to prepare nurses to provide culturally competent compassion.

The importance of spending time with patients is evident in the narratives, but there is also recognition that this time needs to be meaningful and of good quality, as demonstrated through the frequent references to 'presence' in the current study.

Presence is part of the essence of nursing practice and is commensurate with theories of nursing care. Presence involves the personal uniqueness that each nurse brings to the nurse-

patient encounter, and the professional context of that encounter, which is goal-directed (McKivergin &Daubenmire, 1994). There are several different levels of practice and skills required for the practice of presence in nursing. These include physical presence (e.g. seeing, examining, hearing); psychological presence (e.g. assessing, communicating, active listening), and therapeutic presence (e.g. caring, connecting, intuitive knowing;McKivergin &Daubenmire, 1994; Daubenmire, 1990). As a nurse moves through these levels of presence, the nature of contact moves from 'being there' to 'being with' to 'relating to the patient as whole being to whole being' (McKivergin & Daubenmire, 1990). van der Cingel (2011) extends these notions by arguing that 'being there' is a conscious choice and not a coincidence; the nurse notices the need for presence. Presence is intentional.

It is clear that during this type of nurse-patient relationship, nurses give a lot of themselves, and the intentional nature of compassionate practice is also conveyed through the willingness to 'go the extra mile' and engage in acts of kindness that are described as being outside the usual professional role. Individualised, personalised care is also central to compassion according to our respondents. There was universal agreement that patients must be regarded as individuals and their individual beliefs, values, preferences, customs – in other words 'culture'- must be acknowledged and respected.

For Schantz (2007) compassion entails notions of doing good and justice in which there is no place for making judgements about people's deservingness of compassion. In a similar vein, many respondents viewed the defending and advocacy role of the nurse as contributing to compassionate care, echoing Goetz et al.'s (2010) assertion that the primary function of compassion is to facilitate cooperation and protection of the weak and those who suffer.

Across the countries participating in this study, many shared similar views on compassion. Figure 1 summarises the components and actions which relate to the superordinate themes of 'conscious and intentional compassion' and 'socio-political structures'.

[Insert Figure 1 here]

Limitations of the study

Although this on-line survey was an efficient and extremely economical way to collect a large data set in a relatively short period of time, the research team acknowledges that there are a number of weaknesses which need to be borne in mind. Firstly, the selection of the countries involved was dictated by the networks of the lead researcher. Therefore European countries dominate the sample (9 out of 15). The study would have benefited if African countries as well as others such as China and India were part of the sample. Another weakness is the difference in size of the country samples. The smaller the sample, the fewer the examples which may have highlighted the differences between countries.

Conclusion

This study revealed shared understandings of the importance of compassion in nursing practice across 15 countries, as well as some common perceptions of the attributes of compassionate care. This research highlights the conscious and intentional nature of compassion in nursing practice. While expressing organisational constraints, there are numerous examples of nurses rising above the constraints to practice with compassion. The role of organisational culture in nurturing compassion is noted. Further research is needed to explore the subtle but important cultural differences in the enactment of compassion. Such cultural understanding will help nurses and other health professionals in their endeavours to provide culturally competent compassion.

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Table 1: The sample

Country of residence and work of participants	*Number of respondents*
Australia	35
Colombia	103
Cyprus: a)Greek Cypriots	49
b)Turkish Cypriots	73
Czech Republic	142
Greece	94
Hungary	87
Israel	81
Italy	53
Norway	29
Philippines	100
Poland	101
Spain	174
Turkey	96
United Kingdom	56
United States of America	50

TOTAL	**1323**

Figure 1: Superordinate themes, components and actions commonly reported by respondents from the participating countries

SOCIO- POLITICAL STRUCTURES

	COMPONENT	ACTION
CONSCIOUS AND INTENTIONAL COMPASSION	TIME	• To listen • To talk • To hold someone's hand • To support someone • To develop a therapeutic relationship
	BEING THERE	• To be with patient in mind, body and spirit • To register the importance of the moment • To love
	GOING THE EXTRA MILE	• To go beyond one's role • To care outside one's duties • To share common humanity • To volunteer • To talk to family unable to be with their loved one
	DEFENDING & ADVOCATING	• To challenge any injustice • To promote equality • To challenge stereotypes • To challenge discrimination • To promote cultural competence • To acknowledge the uniqueness in the individual expressions of suffering

	PERSONALISATION	• To consider individual's characteristics
		  ○ Gender
		  ○ Age
		  ○ Culture
		  ○ Socio-economics
		• To consider individual's health problems
		  ○ Illness
		  ○ Vulnerability
		  ○ Mental orientation
		  ○ Disabilities

SOCIO-POLITICAL STRUCTURES