Investigating country differences and similarities regarding nurses' views and experiences of compassion: An exploratory international on-line research study

Abstract

Background

Compassion is considered the cornerstone of nursing practice. However, the recent failures in delivering high quality compassionate nursing care in the UK's National Health Service have brought the topic of compassion to the attention of the public, service providers, policy makers and academics.

Aim

The aim of this study was to explore the nurses' views and experiences of a number of compassion-related issues in nursing and describe similarities and differences at an international level as well as from the different nursing roles of the participating nurses.

Methods

An exploratory, cross-sectional descriptive study, using an on-line survey. A total of N=1323 nurses from 15 countries completed the questionnaire.

Results

The majority of participants (59.5%) defined compassion as "Deep awareness of the suffering of others and wish to alleviate it" but definitions of compassion varied by country. 69.6% of participants thought compassion was very important in nursing and more than half (59.6%) of them argued that compassion could be taught. However, only 26.8% reported that the correct amount and level of teaching is provided. The majority of the participants (82.6%) stated that their patients prefer knowledgeable nurses with good interpersonal skills and only 4.3% noted that they are receiving compassion from their managers. A significant relationship of the country of work on nurses' experiences of compassion and views about teaching of compassion was also found.

Conclusion

Our study is unique in identifying the views and experiences of nurses from 15 different countries worldwide. Participants articulated in cultural and contextual ways the differences and similarities in various aspects of compassion in healthcare practice and education. The findings reveal that compassion is neither addressed adequately in nursing education nor supported in the practice environment by managers.

Limitations

Self-report bias was inherent to our survey study design. Furthermore, the individual cultural differences and similarities in the findings are difficult to extrapolate owing to the fact that our analysis was at country level, as well as at the level of the participating nurses.

Implications for Nursing Policy

Understanding the influence of culture on nurses' views about compassion is critical in the current multicultural health care environment. This will potentially drive changes in nursing education and in the way healthcare leaders and managers foster a compassionate culture within their organisations.

Keywords: Compassion, culture, international, nurses' views, quantitative, on-line survey

INTRODUCTION

The recent failures in delivering high quality nursing care in the UK National Health Service have brought the topic of compassion to the forefront and led to the development of the *Compassion in Practice* strategy (DH 2012). This articulates a vision for the development of a culture of compassionate care, but some critics have pointed out that the strategy fails to provide a clear direction to healthcare staff regarding compassionate behaviours and how to achieve them (Dewar et al. 2013). Further, working in a compassionate environment has been suggested as an important contributor to the delivery of compassionate care (Finfgeld-Connett, 2008). We conducted an on-line survey asking nurses from around the world to indicate their experiences and views on a number of current issues on compassion which have been raised in the literature and professional/public debates, aiming to explore possible similarities and differences among countries and among different roles occupied by professional nurses.

Background

Compassion has been defined as 'a deep awareness of others' suffering and a willingness to alleviate it' (Goetz et al. 2010, Schantz 2007). A recent action research programme in Scotland, with a special focus on leadership and compassion, found that an organization can contribute to the delivery of compassionate care by a) supporting staff in the engagement of self-compassion, b) finding ways for continuous involvement in compassionate care and c) assisting staff to experience satisfaction when delivering compassionate care (Dewar et al. 2014). Compassion satisfaction has been identified as a significant motivational factor for delivering high quality nursing care (Burtson et al. 2010) and similarly being compassionate towards oneself has been deemed necessary for being compassionate with others (Gustin et al. 2013).

But, what do we know about nurses' experiences of compassion? When nursing faculties were asked about their experiences of compassion, they focused on the need to form connections with others, but declared that this was often hindered by organizational pressures (Peters 2006). A similar picture was painted by Curtis (2013), who described the challenges that nurse teachers face when teaching compassionate care under unsupportive conditions, such as lack of time and having to teach large student groups.

Supporting nurses to engage in compassionate behaviours in the clinical environment has been advocated (McSherry et al. 2012, Straughair 2012), although little is known about how frequently nurses themselves experience compassion from their leaders.

Anecdotally many NHS Trusts in England report engaging in work which explores their nurses' views about compassion; however we have not been able to identify any published research studies that focus exclusively on exploring the nurses' views and opinions on compassion at an international level.

We hypothesized that nurses' views and experiences of compassion may differ between countries and cultures , and our survey – which was made up of structured and open ended questions- was set up to explore these views. This paper reports only the quantitative findings from this study.

In this paper we define culture as the collective programming of the mind which distinguishes the members of one group or category of people from another (Hofstede 2001). According to Hofstede (2001) culture is manifested at different levels, the deepest of which being that of values. Even though whole nations/countries should not be equated to one group, many countries do form historically developed wholes which may consist of clearly different groups and less integrated minorities. Hofstede (2001) states that rightly or wrongly, collective properties are ascribed to the citizens of certain countries e.g 'typically American', 'typically German' and so on, although we wish to remind the reader that such labels should be used with caution.

Aim

The aim of this study was to explore the nurses' views and experiences of a number of compassion-related issues in nursing and describe similarities and differences at an international level, as well as from the different nursing roles of the participating nurses.

Design

An exploratory, cross-sectional descriptive study, using an on-line survey.

Development of the survey and procedures

'*The international on-line Compassion Questionnaire'* survey was created by the first author (principal investigator) and was based on key themes drawn out of published literature within the field of nursing compassion, on-line nursing discussion forums, and public/professional blogs around the topic of compassion. The survey consisted of standalone open-ended and closed questions. As such it is not an 'instrument' that we can calculate reliability measures of stability or equivalence, therefore these are not reported.

The survey included questions about the definition of compassion, the importance of compassion in nursing, whether compassion can be taught, the level at which compassion is being taught, the nurses' experiences of compassion, their views on how a person develops compassion and their perceptions about the patients' preferences of care (please see Table 1 for specific survey questions).

The survey was piloted with a sample of South Korean nurses (N = 74). The majority of Korean Nurses (50.7%) defined compassion as 'a deep awareness of the suffering of others and a wish to alleviate it'; they believed that compassion can be taught (64.4%) and that compassion is 'important' for nursing (67%). Many of them also felt that their patients' prefer to be nursed by 'knowledgeable and compassionate nurses' (45%), and that nurses mostly experience compassion from their patients (80.9%). Following the pilot the questionnaire was slightly modified in order to improve the clarity of the questions and a few questions were added to capture the participants' ethnicity and nursing roles (e.g. qualified nurse, nurse teacher, final year student nurse).

For the purpose of the main study, the lead researcher recruited two volunteer co-researchers from each of the participating countries, the role of whom, apart from recruiting participants, included the translation and back translation of the questionnaire into their native language to assure the quality and accuracy of the translation, using the World Health Organisation (WHO) guidelines for instrument translation (http://www.who.int/substance_abuse/research_tools/translation/en/). In addition co-researchers were asked to translate the participant invitation/information letter, as well as the collected qualitative data.

Snowball sampling was used for recruitment and for this reason a response rate does not apply. The co-researchers from each country distributed the survey questionnaire to their network of nurses during the period from January 2014 to April 2014. Individuals were eligible to take part if they were a qualified nurse, final year student nurse, nurse educator, or a nurse manager. Participants were encouraged to forward the survey link to their fellow colleagues.

The invitation letter informed potential participants of the aim of the survey, the name of the ethics committee/s which provided ethical approval for the study, and emphasised that participation was anonymous, confidential and voluntary. Web-based electronic survey software was used to collect data in each of the participating countries. Participants were emailed a web-link to the survey which enabled them to complete the survey on-line. The electronic survey was presented in each of the host country's language. For participants who could not access the online survey, paper versions of the questionnaire were used. From the total of 1323 questionnaires, 179 were completed on paper as follows:

Philippines- 100, Italy- 22, and Turkish Cypriot- 57.

The initial goal was to recruit 50 participants from each country, however most countries exceeded this target. The initial sample size goal for each country was not based on a power sample calculation since the nature of the project was exploratory and descriptive. Our intention was however, to ensure a reasonable sample size from each country that could provide the opportunity for comparisons between the countries.

Nurses from the following 15 countries participated in the online survey: 1) Australia, 2) Cyprus[1] [a)Greek & b)Turkish Cypriots], 3) Czech Republic, 4) Greece, 5) Hungary, 6) Italy, 7) Israel, 8) Norway, 9) Philippines, 10) Poland, 11) Colombia, 12) Spain, 13) Turkey, 14) United Kingdom and 15) USA.

Ethical considerations

[1] Because of the current partition of the island of Cyprus we collected two separate sets of data in order to adequately represent the Greek and Turkish speaking Cypriots.

Ethics committee approval was obtained from the lead researcher's university (ethics subcommittee; Health Studies, Application Ref: MHESC1401) and the participating co-researchers ensured that local country regulations were followed.

Data Analysis

The data from all countries were analysed using SPSS statistical software (version 22), and descriptive analysis was undertaken. Data were also compared between countries and relationships between variables were explored using chi square tests and analysis of variance and Bonferroni post-hoc tests were employed when appropriate. Bonferroni correction was also applied when necessary in order to avoid Type 1 error in post-hoc subgroup analysis. The level of significance was set at $a = 0.05$.

RESULTS

A convenience sample of N=1323 nurses responded to the survey from the following 15 countries: 1) Australia (N=35), 2) Cyprus [(a)Greek Cypriots (N = 49) & (b)Turkish Cypriots (N =73)], 3) Czech Republic (N=142), 4) Greece (N=94), 5) Hungary (N=87), 6) Italy (N=53), 7) Israel (N=81), 8) Norway (N=29), 9) Philippines (N=100), 10) Poland (N=101), 11) Colombia (N=103), 12) Spain (N=174), 13) Turkey (N=96), 14) United Kingdom (N=56) and 15) USA (N=50).

Out of the 1323 participants, the 45.4% were practicing qualified nurses. (Table 1) Overall the majority of the participants (59.5%) defined compassion as "Deep awareness of the suffering of others and wish to alleviate it" and the 69.6% thought that compassion was very important in nursing. Although more than half (59.6%) of them felt that compassion could be taught to nurses, 44.3% stated that not enough compassion teaching is provided.

When asked for their views regarding patients' preferences, the majority of participants (82.6%) thought that their patients prefer knowledgeable nurses with good interpersonal skills. Approximately half (51.1%) of them stated that patients value medical treatment more than compassion. When asked about the most important factor for the development of compassion, family, cultural values and personal experiences of compassion were rated similarly. Finally, participants were asked to indicate from whom nurses in their country

experience compassion and surprisingly only 4.3% noted that nurses receive compassion from their managers.

The researchers carried out two sets of analyses. The first one focused on the differences amongst countries in regards to nurses' definition of compassion, their views on teaching compassion and their experiences of compassion. For this purpose an ANOVA (analysis of variance) was carried out and significant differences were found between the countries on their definition of compassion; $F(14,1106)=21.035$, $p<0.0001$, their views on the possibility of teaching compassion; ; $F(15,1300)=5.226$, $p<0.0001$, the level of compassion being taught to nurses; $F(14, 1106)=5.254$, $p<0.0001$ and finally their experiences of compassion $F(14,1106)=7.838$, $p<0.0001$.

Due to significant differences found in the main analysis, further post-hoc tests were carried out by the researchers in order to compare countries. A Bonferroni Correction was applied when necessary in order to avoid family-wise error.

The first set of post-hoc test was carried out on the definition of compassion. Results showed that the majority of participants from Cyprus (both Greek and Turkish speaking), UK, and the Philippines defined compassion as "Empathy and Kindness", whereas nurses from the other countries defined compassion as "Deep awareness of the suffering of others and a wish to alleviate it"; with nurses from Israel, Colombia and Spain overwhelmingly choosing this definition of compassion.

With regards to teaching compassion, participants from the Philippines were the most positive by stating "Yes, it is possible to teach compassion". They significantly differed in their responses from those of the Turkish Cypriots, USA, UK, Czech Republic, Poland, Hungary and Italy, who were more likely to report that 'No' or 'Do not know' whether compassion can be taught. The majority of the participants from Philippines (57.6%) also reported that "The correct amount of teaching is provided". They significantly differed in their responses from the respondents in other countries, particularly from the Spanish participants who were found to be the least positive with regard to the level of compassion teaching being provided. Furthermore, participants from Cyprus (Greek & Turkish speaking),

Turkey, Greece, Poland, Hungary, Colombia, Norway and Israel, reported that "Some teaching is being provided", and significantly differ from their Philippino and Spanish counterparts.

A final post-hoc test was carried out on nurses' experiences of compassion. Results showed that Turkish (64.4%) and Greek Cypriot (66%) participants, along with those from the USA (56.5%), UK (66%), Greece (50%), Hungary (48.1%), Spain (50.6%), Australia (61.8%), Norway (60.7%) and Israel (62.2%), reported having experienced compassion mainly from their colleagues. In contrast, those from the Philippines (51%), Italy (84.6%), Turkey (55.4%), Poland (55.7%), and Colombia (84.7%) indicated experiencing compassion mainly from their patients. Participants from Australia, Italy and Israel did not report experiencing compassion from their managers at all. Participants from the Philippines (39.6%) and Turkish Cypriots (20.8%) were the most likely to state that they experience compassion from their managers, as opposed to nurses from the other participating countries

The second set of analysis was relational as the researchers wanted to assess the relationship between the nurses' experiences of compassion and the way they defined it, as well as their experiences of compassion and views on its teaching (See Table 2). Nurses' country of work was not used as a control variable for this analysis as the researchers wanted to assess the differences between the nurses' perceptions with regard to definition and the importance of compassion depending on the source which they receive compassion from. Those who stated that they experienced compassion from their managers were more likely to define compassion as "Empathy and Kindness", whereas those who reported that they experienced compassion from either colleagues or patients were more likely to define it as "Deep awareness of the suffering of others and wish to alleviate it" (See Table 2).

Nurses' thoughts on teaching of compassion and their opinions on the level of teaching being provided with regard to compassion also differed depending on their experiences of it. Most of the participants suggested that it is possible to teach compassion (See Table 2). However, those who stated that they experienced compassion from their managers were significantly more likely to say that "yes it is possible to teach compassion" ($t(52)=3.667$, $p=.001$) than those who reported receiving compassion from patients, who were significantly more likely

to state that it is not possible to teach compassion ($t(52)=-10.215$, $p<.001$). Participants who stated that they received compassion mostly from their patients were also significantly more likely to say "Do not know" compared to those who reported receiving compassion from their managers ($t(52)=-24.097$, $p<.001$). No significant differences were found between the "Colleague" and "Patient" groups in terms of their views about whether compassion can be taught, ($F(1,1189)=1.687$, $p=0.134$) (See Table 2).

With regards to the amount of teaching provided, participants who stated experiencing compassion from their managers were more likely than those who experience compassion from either "Colleagues" or "Patients" to say that the "Correct amount and level of teaching is provided". The other groups were more likely to say "Not enough teaching is being provided". Significant differences were also identified when the "Manager" and "Patient" groups were compared overall ($F(1,664)=39.920$, $p<0.001$). Those in the "Patient" group were significantly less likely to say that "The correct amount and level of teaching is being provided" ($t(52)=6.149$,$p<.001$) compared to those in the "Manager" group. They were, however, significantly more likely to say "Not enough teaching is provided" ($t(52)=-7.719$, $p<.001$) or "Do not know" ($t(52)=-14.653$, $p<.001$). Similar to the "Manager" and "Colleague" groups "Manager" and "Patient" groups did not differ significantly when stating "Some teaching is provided"($t(52)=-0.785$, $p=0.436$). Finally, when comparing "Patient" and "Colleague" groups no significant differences were found *(*$F(1,1189)=0.385$, $p=0.403$.

Finally, an analysis of variance was carried out in order to assess whether the source of compassion differed amongst the occupation groups (final year nursing student, practicing nurse, lecturers/nurse educators). Overall there was a significant difference between the groups; $F(3,1168)=9.783$, $p<.0001$. Those who were practicing nurses were more likely to state that they experience compassion from their colleagues or from their managers compared to the final year nurse students (See Table 3). In addition, practicing nurses were less likely to state that they experience compassion from their patients compared to final year nurse students and the nurse educators/lecturers (See Table 3).

DISCUSSION

The results of our study showed a significant relationship of the country of work on nurses' definitions and experiences of compassion. It was also found that the nurses' perceptions on whether compassion can be taught, and the level of teaching that is currently being provided varied depending on their country of work. In addition, perceptions of the source of compassion received by nurses was also identified to be related with their definition of compassion, their thoughts on whether compassion can be taught, and the level of teaching that is currently being provided.

According to researchers such as Larson (2014), Attree (2001), Goetz (2004) and Tweddle (2007), compassion is dependent on one's cultural background and spirituality. This could partially explain the differences and similarities with regard to the definition of compassion among the participants of the countries in the current study. In addition, environmental factors surrounding the individual also have an impact on compassion. For example, individuals from countries where there is conflict or war tend to be less compassionate (Goetz 2004; Stewart 2009). It is, therefore, particularly important to understand and examine compassion in different countries where recent conflict has been experienced such as Cyprus and Turkey. In fact in our study, participants from Cyprus were more likely to report 'No' or 'Don't know' on the question about whether compassion can be taught.

Recent research has suggested that in addition to one's cultural background, the culture of organisations is an important factor for the development of compassion (Dewar et al. (2011); McCormack et al. (2008); Powell et al. (2009); Smith et al. (2010)). There is also evidence that organisations could create a co-operative environment for compassion by forming collective values, relations, personal skills and beliefs (Hegney et al. 2014). This consequently influences the employees' compassion towards themselves as well as others (Dutton et al. 2007).

According to Brodbeck et al. (2002), acceptable norms and behaviour are defined by societal and organizational culture. If compassion, therefore, is seen as an acceptable behaviour in a society or organisation, people are more likely to adopt such behaviour. If, therefore, nurses experience compassion at work they are also more likely to be more compassionate to their colleagues and to patients in their care (Frampton and Goodrich, 2014). Although as

suggested by Pendelton and King (2002) and Rynes, Bartunek, Dutton and Margolis (2012), managers play an important role in developing a compassionate culture at an organisational level, our study indicated that the large majority of nurses worldwide unfortunately seem to perceive that managers exhibit low levels of compassion. In accordance with our findings in a US sample only 7% of hospital employees reported receiving compassion from their supervisors (Lilius et al. 2008).

In collectivist societies such as India and Japan, people place more emphasis on interdependence, group harmony and group goals (Barkema, et al 2015). According to researchers such as Canevello and Crocker (2010), the importance given to group relations in such societies may strengthen compassion. For example, Evans(2015) suggested that relationships are greatly valued in the Philippines (considered as a collectivist society). Individuals expect to be cared for with compassion where the individual's support system, which may consist of family, friends or a health professional, is accustomed to duties such as providing compassionate care, empathy and listening, particularly during difficult situations (Lopez, 2011). Parallel to this, our study identified that in particular, nurses from the Philippines and those from the Turkish speaking Cypriot group, both of which are classified as collectivist societies, reported receiving more compassion from their managers.

Contradictory to these findings however, our results showed that similar to nurses from Australia, those from Italy and Israel who are also considered collectivist in their culture (Hofstede 2001) reported not receiving compassion from their managers. This may be explained by research reported by Storey and Holti (2013),Dewar et al. (2011); McCormack et al. (2008); Powell et al. (2009); and Smith et al. (2010) which suggest that in addition to cultural dimensions, other factors, such as efficiency, performance targets and fear of appearing unprofessional may influence managers to show less compassion towards their employees.

Gilbert (2009) suggested that nurses often feel stressed because emphasis is placed mainly on the quantifiable consequences of their work such as technical skill, rather than the care that they provide to their patients and to their colleagues. It appears that individualistic societies, such as the UK and the USA, place more emphasis on competition, individual achievement and meeting targets, than compassion and kindness which may be perceived as a weakness or

a luxury (Gilbert 2009). This could partially explain that the UK and USA nurses in our sample tend to more often report 'No'or 'Don't know' to the question whether compassion can be taught.

The King's Fund (2012) warned healthcare managers that if only economic factors and efficiency are perceived as important, it can have significantly adverse effects on the way employees feel about the value placed on their work as care-givers. In a previous King's Fund report (Firth-Cozens et al. 2009) it was reported that the nurses' compassion starts to lessen within 2 years of starting work due to pressure from managers on completing tasks and meeting targets. These conclusions echo our findings regarding the worrying lack of compassion shown by managers to front line staff.

Participants' views on whether or not compassion can be taught were also dependent on the source from which they personally received compassion. There is considerable debate with regard to whether compassion is innate or learnt. According to Magalhães et al. (2012), some students are more empathetic from birth and are therefore more likely to be caring and compassionate in their practice with or without receiving any specific training in compassion. This view was expressed by a sizeable minority of our sample (25%). However, this opposes the view of the majority of our sample, and that of other nurse educators and practitioners who believe that compassion is a skill that is developed during training (Kelley & Kelley, 2013). Aristotle (384 -322BCE), suggested that compassion is a virtue that is mastered through practice and positive role modelling. The influence of authority on our behaviour was investigated by Milgram (cited by Pence 1983) who conducted a series of experiments following concerns in regards to obedience to authority which had been identified during World War II. Milgram's results suggest that moral virtues such as compassion can be ignored or expressed depending on the behaviour of an authoritative figure. Therefore it can be argued that if authoritative figures such as managers and supervisors display compassion towards their employees (in our case nurses), it may encourage them to express compassion towards their patients and each other.

The positive impact of modelling by managers was also supported by the findings of our research whereby those who reported receiving compassion from their managers were found to be more positive regarding the possibility of teaching compassion. With the growing body

of literature supporting the important role of leaders/managers on nurturing and enabling compassion in organisations, it is not surprising that if one receives compassion from their managers they will also be more positive with regards to teaching and nurturing it in others (Bramleu and Matiti, 2014, Cornwell et al. 2009, Gilbert 2009, Worline et al. 2006).

Limitations

Due to the cross-sectional nature of the study it is not possible to detect causality. Some of the results may be prone to Type 2 Error due to having a smaller number of participants in some cells (see table 1). Furthermore, the individual cultural differences and similarities in the findings are difficult to extrapolate owing to the fact that our analysis was at country level.

CONCLUSION

Our study is unique in identifying the views and experiences of nurses from 15 different countries worldwide, allowing us to identify differences and similarities in various aspects of compassion in healthcare practice and education.

The results of our study concur with results from other studies which indicate that in order to achieve a compassionate healthcare workforce, undergraduate and continuous professional education, must include relevant content and learning activities. Nursing is now a global activity with large numbers of nurses moving across the world in search for work and better opportunities. To achieve their successful integration in the host countries and to ensure that nursing is practice with compassion we must first understand *how* nurses from around the world *define and experience* compassion.

Our findings also highlight the need to urgently address the lack of compassion from managers to their nursing staff. As leaders, managers within organisations must lead by example and it should be their priority to create organisational structures that promote and sustain compassionate behaviours.

A larger international survey is needed to verify the results of this exploratory study. Additional qualitative research is also needed in order to provide the narratives needed to underpin the quantitative results.

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Table 1: Number of Participants and Valid percentages on survey questions (n = 1323)

Survey Questions	Percentage (%)	N
Please select the option which applies to you		
I am a final year student nurse	9.9	131
I am a qualified practicing nurse	45.4	600
I am a nurse educator/ lecturer/or nurse manager	29.3	387
Other		
Did not state	8.0	106
	7.5	99
How would you define the term compassion?		
Empathy and kindness	28.2	370
Deep awareness of the suffering of others	9.3	122
Deep awareness of the suffering of others and a wish	59.5	780
to alleviate it	3.0	40
Other		
How important is compassion in nursing?		
Not very important	2.7	36
Important	27.6	364
Very important	69.6	917
Do you believe that compassion can be taught to nurses?	59.6	784
Yes	25.2	332
No	15.2	200
Don't know		
Do you believe that compassion is being taught to nurses?	11.1	145
The correct amount and level of teaching is provided	26.8	351
Some teaching is provided	44.3	581
Not enough teaching is provided	17.9	235
Don't know		
Do you think patients prefer to be nursed by:	82.6	1082
Knowledgeable nurses with good interpersonal skills	14.4	188
Knowledgeable nurses with good technical skills	3.1	40
Knowledgeable nurses with good management skills		
In your view, which is the most important influence for developing compassion?		
The person's family	30.5	400
The person's cultural values	34.2	449
The person's personal experience of compassion	35.2	462
Please select the statement you most agree with		
patients value efficiency more than compassion	32.7	414
patients value the use of medical technology more	16.1	204
than compassion	51.1	647
patients value medical treatment more than compassionate caring		
Please select the statement you most agree with		
Nurses in [country] experience compassion from	4.3	53
their managers	46.3	582

Nurses in [country] experience compassion from their colleagues	49.4	622
Nurses in [country] experience compassion from their patients		

Table 2: Descriptive Table Showing the Percentages and the Count of and the Relationship (X^2) Between the Nurse's Experiences of Compassion by Definition of Compassion, Perceptions of Teaching Compassion and the Level of Compassion Teaching that is being provided in Respondents' Countries of Work

		Nurses' Experiences of Compassion		
		From Managers	**From Colleagues**	**From Patients**
		% (N)	%(N)	%(N)
How would you define the term compassion?	**Empathy and Kindness**	50.9%(27)	30.4%(177)	24.3%(151)
	Deep awareness of the suffering of others	5.7%(3)	10.6%(62)	7.6%(47)
	Deep Awareness of the suffering of others and a wish to alleviate it	43.4%(23)	55.9%(326)	63.8%(397)
	Other	0%(0)	2.7%(16)	3.4%(21)
Chi Square	$X^2(6,1250)=25.407, p<.001$			
Do you believe that compassion can be taught to nurses	**Yes**	77.4%(41)	60.4%(350)	58.5%(364)
	No	18.9%(10)	21.9%(127)	28.5%(177)
	Do not know	3.8%(2)	17.6%(102)	12.9%(80)
Chi Square	$X^2(4) =17.918, p=.001$			
Do you believe that compassion is being taught to nurses?	**The correct amount and level of teaching is provided**	49.1% (26)	9.7% (56)	9.7%(60)
	Some teaching is being provided	24.5%(13)	25.7%(148)	28.4%(176)
	Not enough teaching is provided	15.1%(8)	45% (260)	46.3%(286)
	Do not know	11.3%(6)	19.7%(114)	15.6%(97)
Chi Square	$X^2(6) =85.160, p<.001.$			

Table 3: Frequency Table showing the percentages of the Source of Compassion by Occupation Group

		Source of compassion		
		Managers	Colleagues	Patients
Occupation	Final Year Nursing Student	2.3%	40.8%	56.5%
	Practicing Nurse	7%	49.5%	41.8%
	Lecturers/Nurse Educators	1.6%	45.3%	49.9%