

Exploring Nurses' Meaning and Experiences of Compassion: An International Online Survey Involving 15 Countries

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Abstract

Purpose: In recent years, there has been much focus on compassion in nursing care, and concern has been raised in a number of reports and media stories regarding decreased compassion. The aim of this study was to explore similarities and differences in the understanding and demonstration of compassion in nursing practice across 15 countries. **Design:** A total of 1,323 nurses from 15 countries responded to questions in relation to compassion, via an international online survey. **Results:** The data revealed the impact of sociopolitical influences on perceptions of compassion, and the conscious and

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intentional nature of compassion. **Discussion and Conclusion:** The study demonstrated shared understandings of the importance of compassion as well as some common perceptions of the attributes of compassionate care. The differences reported were not as significant as had been expected. **Implications for Practice:** Further research is needed to explore the country and culture differences in the enactment of compassion.

Keywords

compassion, cultural competence, culture, transcultural nursing

Introduction

In recent years, there has been much attention to the fact that compassion in health care seems to have decreased, with alarming reports and media stories further raising this issue. The impetus for this study was a series of reports of unsatisfactory care and lack of compassion in health care provision in the United Kingdom, notably the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis, 2013). The report included recommendations for an enhanced focus on a compassion and caring in nurse recruitment, training, and education. A literature review revealed that discussion and debate surrounding the notion of compassion is evident globally (Chrousos, 2014; Goetz, Keltner, & Simon-Thomas, 2010; Schantz, 2007; van der Cingel, 2011). 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 online survey are reported in this article. Participants were asked to respond to 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.

While some of the issues raised in this article are specific to the provision of compassionate nursing care in the United Kingdom, the issues surrounding compassion and the findings of our study cross international boundaries and enhance our understanding of compassion in nursing.

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; Centre for Applied Research and Evaluation International Foundation, 2013; Straughair, 2012): It is a central focus of many spiritual and ethical traditions, from Buddhism to Confucianism to Christianity (Goetz et al., 2010).

The NHS Commissioning Board (2012) for England 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. (p. 13)

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, as cited in Papadopoulos & Pezzella, 2015, p. 2)

The attributes of compassion are believed to include the following: a subjective experience that recognizes 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 while compassion is innate, it is subsequently learned through socialization. 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 polarized 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 online 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 coresearchers from each of the participating countries listed below. The role of the coresearchers 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, coresearchers 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 emphasized that their participation was anonymous, confidential, and voluntary. Researchers were provided with common guidelines during the various key stages of the study, such as how to assure the quality of translations, the sample criteria, and how to recruit participants, and so on. Guidelines on how to conduct thematic analysis was sent to a small number of researchers who eventually analyzed their own countries’ data for verification purposes. Web-based electronic survey software was used to collect data in each country.

As a consequence of globalization, 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.

Table 1. The Sample.

Country of residence and work of participants	Number of respondents
Australia	35
Colombia	103
Cyprus	
Greek Cypriots	49
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	1,323

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. (2010) further argue that nations should not be equated to societies, which are forms of social organization, and in research on cultural similarities and differences, nationality should be used with care. Mobility of health professionals has resulted in multiethnic, multicultural workforces in many of the countries participating in this survey. For example, respondents from the United Kingdom described themselves as Asian, Australian, Black Caribbean, British, Indian, Irish, and 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 organizational 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, 1,323 respondents from 15 countries participated, out of which 9.9% was final year nursing students, 45.4% was practicing qualified nurses, and 29.3% was lecturers/nurse educators or nurse managers. A small percentage (8%) of responders chose the “Other” category, while 7.5% did not state their occupation (refer to Table 1).

Data Collection

Each researcher/coordinator distributed the questionnaire to their network of nurses. Participants completed the survey online. 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 coresearchers/coordinators from each country undertook the translation into English, while 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, analyze, 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 components and actions. These were subsequently embedded onto two superordinate themes (see Figure 1).

Results

The results reported in this article begin with the definitions of compassion and then proceed to convey the impact of the two superordinate themes, those of “sociopolitical structures” and the “conscious and intentional nature of compassion.”

The majority of the participants reported that compassion is very important to nursing and defined it as “a deep awareness of the suffering of others and a wish to alleviate it.” There were, however, some definitions that either added to or contested this. For example, one of the participants from the Czech Republic referred to it as “empathy in the spirit of following the emotions of the other person, effort to connect to the person, and effort to find together a path to mitigate the problems of his or her suffering.” A participant from the United States stated that “it is a desire to help and [provide] service to others.” A Turkish Cypriot participant defined compassion as “good and equal care.” Participants from Colombia also highlighted the issue of equality in their definitions as for example “being able to see the others as equal and include them with respect in their sadness, in their joy, in their adversity or in their walk through life. Never from a moralistic perspective but with an attitude of solidarity.” Another Colombian participant defined compassion as “the humility to see others as equals which has to do with learning to give and receive compassion.”

Some Italian and Norwegian participants reported they could not define compassion as it is the nurse’s job to know how to alleviate suffering. Compassion is going beyond the role of the nurse. A participant from Spain reported that “I do not like to use the term compassion due to the fact that it has been linked to religious beliefs, [thus] removing the importance of scientific evidence in nursing care.”

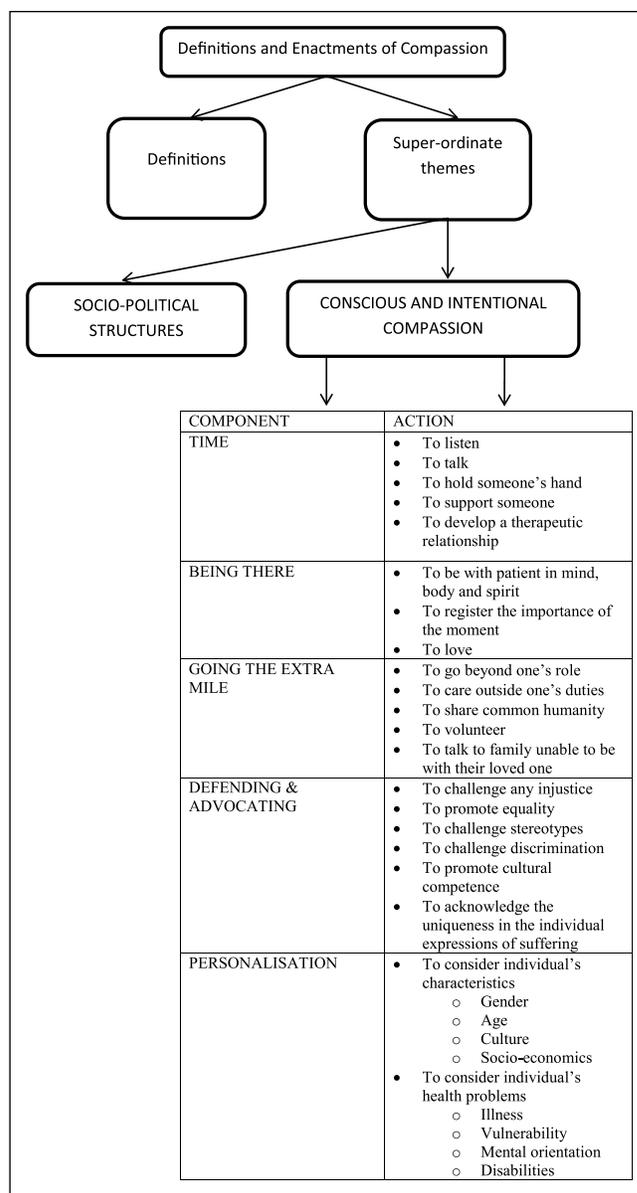


Figure 1. Visual representation of the analysis.

The data revealed a number of components and actions, many confirming a global appreciation of elements of compassion that are already recognized.

Superordinate Theme 1: Sociopolitical Structures

Problems of quality and safety exist in health care systems worldwide (Dixon-Woods et al., 2014). In the research reported here, there was evidence of nurses feeling constrained and influenced by sociopolitical structural issues that affect the delivery of care.

Sociopolitical structures determine the context in which health care is provided and thus the macro environment in which nurses practice. Decisions about the funding of, and

access to, health care can have ramifications beyond health care services to affect wider society and societal relationships. Our respondents appear to be acutely aware of the influences of sociopolitical decisions on their actions. While there are differences in the way health care is delivered between the countries surveyed in this study, for example, in terms of degrees of poverty, stability, and levels of coverage of health care, our respondents demonstrated many similarities in terms of their roles in relation to the provision of compassionate care.

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 United Kingdom, legacy of lack of universal coverage in the United States, conflict in Colombia, and austerity measures in Greece:

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

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 [of] tasks. (United States)

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 sociopolitical barriers to providing compassionate care. The findings are pleas to policy makers and organization leaders to place patients at the center of the organization, and nurture the development of caring cultures by valuing staff and patients.

Superordinate Theme 2: The Conscious and Intentional Nature of Compassion

In spite of perceived constraints, which are seen as negative forces which prevent the provision of culturally competent compassion, 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 or her family.” There was evidence of awareness of the need to consider patients' culture, religion, socioeconomic status, and ability, with particular attention to those people who may be “underserved” by health care systems. The role of the nurse as a “defender” or “advocate” was also evident in relation to the provision of compassionate care.

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

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. (United States)

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

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)

In our country displaced families suffer the effects of war, here the nurse is an important support to alleviate this suffering, establishing support networks, listening. (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. (United Kingdom)

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)

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. (United States)

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)

Going the Extra Mile. Compassionate intentional and conscious practice is also characterized by engaging in activities that may be viewed as over and above the usual role of the nurse, or "going the extra mile."

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. (United States)

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)

Individuality/Personalization. Taking account of patients' individual characteristics such as age, socioeconomic 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. (United States)

[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 personalize 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 and emergency department without the requisite identification papers. The respondent reported that

in Colombia this is considered as child abuse by neglect, and the social worker decided to report to the competent authority. In the anguish of her parents for such a complaint and the notice that the child should be taken by the protection state office, I talked with the parents to identify the reason for the situation. They told me that they did not know what was the civil registry and they didn't see any importance because they did not conceive themselves as Colombians but as Emberas indigenous people and therefore did not make sense to have identification papers as Colombians. Given the situation I suggested to parents to comply with this requirement to avoid difficulties. After achieving the commitment of parents I decided to stop the process that was started by the institution, . . . I acted against the norm and even against my truth value but with the conviction that above the rules are the people and their particular realities. (Colombia)

Another example of individualized 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)

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 empathize 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 organizational 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 Daubemire 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” (p. 66). The findings of our study echo McKivergin and Daubemire's (1994) 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 (Crawford, Brown, Kvangarsnes, & Gilbert, 2014; Dixon-Woods et al., 2014). However, England is not alone in experiencing organizational crises in health care. The narratives of the respondents in the current study also point to organizational cultures that prioritize efficiency and making savings over high-quality care.

Indeed, organizational culture is recognized 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).

However, it must be acknowledged that this emphasis on compassion is set in an increasingly complex health care system (Dewar, 2013). As a consequence of rising standards of living and advances in technology, people are living longer. Nurses are caring for people with several comorbidities, which require support from social services as well as health care services, and can be challenging. Pressure to discharge patients from hospital in order to release beds can result in a very high turnover of patients and pressure on nurses. These

situations can contribute to a conflict between professional ideals and practice realities that derive from current economics of health care provision, bureaucracy, and the drive to meet targets (Curtis, 2013; Henderson, 2002). Student nurses, in particular, may experience two versions of nursing—one in the classroom and one in practice—which can lead to disillusionment (Curtis, Horton, & Smith, 2012).

The current study suggests that some nurses are able to rise above organizational constraints and provide care with compassion. This appears to be achieved through the conscious and intentional nature of compassionate acts that recognize the importance of transcending the organizational culture in order to meet patients' needs. Some of the narratives provided by our participants also indicate that individualized 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; Daubenmire, 1990; McKivergin & Daubenmire, 1994). 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, 1994). 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. However, such acts may carry a cost to the caregiver. When a care provider feels a patient's distress through empathy, she or he may also become distressed (Chrousos, 2014). When considering lack of compassion, there is a tendency for emphasis on the individual nurse rather than the environment in which care is enacted. Therefore, there is a need to provide a supportive environment and promote coping mechanisms if compassion in care providers is to be nurtured (Chrousos, 2014; Seager, 2014).

Individualized, personalized 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 judgments 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 summarizes the components and actions which relate to the superordinate themes of "conscious and intentional compassion" and "sociopolitical structures."

Limitations of the Study

Although this online 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. First, 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.

We had intended to use ethnicity as a variable for analysis with which to capture the cultural similarities and differences in the participating countries. We realized that this was very complex since some countries' participants were from multiple ethnic groups and we have no way to measure their integration into the host country. Instead, we opted to adopt the practice used in other international studies such as that of Hofstede as reported in the methodology section.

Although the discussion refers to global literature on compassion, it is acknowledged that it is Anglocentric. Obtaining literature in English referring to nursing compassion issues from the non-English-speaking countries proved very difficult. As to literature on culturally competent compassion, this is almost nonexistent in all countries. However, it is hoped that the findings presented in this article will be applicable widely and will stimulate debate and more research on the topic.

Due to word limitations, a detailed account regarding the demographic (excluding ethnicity) and professional profiles of the researchers as well as the participants have not been included. These will be reported in an article currently under consideration which deals with the quantitative data collected in this survey.

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 organizational constraints, there are numerous examples of nurses rising above the constraints to practice with compassion. The role of organizational culture in nurturing compassion is noted. Further research is needed to explore the subtle but important cultural differences in the enactment of compassion. Further country-specific qualitative research, which should include in-depth interviews, focus groups, and case studies would offer the cultural understanding to help nurses and other health professionals in their endeavors to provide culturally competent compassion.

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