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Hospital Nurses' Experiences and Expectations of Compassion and Compassionate Leadership

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Abstract

Rationale and aim

Nurses caring for critically ill patients need compassionate attention and support, especially during exceptional times. The aim of this study was to provide a trustworthy description of nurses' experiences and expectations for compassionate leadership and compassion at a central hospital in Finland. The study was conducted during the early stage of the Coronavirus 2019 pandemic.

Ethical issues and approval

The voluntary nature and anonymity of the survey was stressed in the cover letter, to make sure that participants did not perceive any undue influence caused by participating in the study.

Methods

The participants were 50 intensive care and emergency nurses of a central hospital. An online survey tool with open questions was used to collect data on the meaning of compassion and on nurses' experiences and expectations of compassion and compassionate leadership.

Inductive content analysis was used to analyze the data.

Results

The nurses reported a great variety of positive experiences of compassion, although the emphasis in this study seemed to be on the absence of compassion, especially in regards to leadership. The nurses expected individual attention and genuine physical and psychological presence from their immediate supervisors.

Study limitations

One researcher analyzed the data, which can cause some bias into the qualitative analysis.

Conclusions

Immediate supervisors express compassion by being physically present and by fostering an open dialogue. Compassion received from leaders and colleagues may be reproduced in patient contacts, which can increase patients' confidence and psychological safety.

Participatory and simulation-based learning methods, which involve shared reflection, are recommended for compassionate leadership skills.

Keywords

experience, compassion, compassionate leadership, healthcare professional, qualitative research

Word count: 5128

Background

Nurse leaders are morally responsible for ensuring that nurses are provided empathy, compassion and concrete interventions to support their well-being (1). Compassion is an old religious and spiritual concept, increasingly receiving attention from the scientific community. An increasing body of literature on compassion has emerged over the past two decades (2). Compassion is also a core value in the Code of Ethics for Nurses of the International Council of Nurses (3). It has been defined as awareness of another person's suffering, feeling for it and motivation to act to share or alleviate the universal experience of suffering (4,5). Compassion has been viewed as "nursing's most precious asset" (6) and a fundamental element of nursing care (7). It is, however, impossible to recognize, quantify or monitor it for effectiveness without a standard definition and a measurement scale (8).

Several concept analyses of compassion exist. Taylor et al. (9) stated that compassion is a complex, subjectively displayed term. Based on their analysis, they suggested five defining attributes for compassion in the healthcare setting: cognitive recognition of another individual's adversities; personal connection with the individual; altruistic desire to help; humanistic response or understanding; and responsive behavior. Although set in the nurse-patient context, the defining attributes might also be relevant for compassion between leaders and employees, or among peers (9). Alternatively, compassion can be viewed as a process with three main elements: becoming conscious of another person's situation; emotional connection; and action taken to alleviate suffering (10).

Attempts have been made to differentiate between compassion, empathy and sympathy. Sinclair et al. (11) stated that sympathy has usually been defined as an emotional reaction of pity, whereas empathy refers to understanding, and accurately acknowledging and responding to another individual's feelings. In many definitions, compassion differs from sympathy and empathy in its proactive approach and the more selfless role of the responder (11). In other words, compassion is seen a step further from empathy, converting empathy into an act aimed at the alleviation of suffering (12). Schantz (6) compared compassion, empathy, sympathy and caring (a state of mind related to worries, anxiety or concern), and maintained that compassion was the one that impelled people to purposeful action to alleviate suffering. Compassion eludes definition, because it intrinsically involves moral and spiritual values (6, 13).

Recent definitions for compassionate leadership seem to rest on altruistic values, emotional intelligence and certain leadership behaviors. Shuck et al. (14) developed a model with six behaviors, which can be applied to leaders and staff alike: integrity, accountability, presence,

empathy, authenticity and dignity. Individuals portrayed in this model appreciate the worth of all human beings and do not hide their vulnerabilities and humanness. They are able to focus and listen, provide honest feedback and are true to their word (14). Like Schuck, de Zulueta (15) in her integrative review called for a change of paradigm from a culture of fear and blame to that of altruistic support, learning, and openness. In such culture, compassionate leadership would involve focusing on the needs of other people, on serving them. The idea, taken further, could lead to shared leadership, in which teams become responsible for decision-making (15). Both Shuck and de Zulueta's thinking are based on the notion that leadership is a dynamic process.

Compassionate leadership may require emotional intelligence, which has been defined as knowledge about emotions, ability to apply the knowledge in emotional situations and the tendency to use emotional skills (16). These skills call for both cognitive and affective empathy, or conscious reading of other individuals' perspectives, and appropriate emotional responses to their emotions (17). It should also be mentioned that self-care interventions are receiving attention as part of a compassionate work environment (18).

Research conducted with intensive care nurses has revealed that respect and support from leaders and colleagues, and providing patient-centered care, may enhance the nurses' experience of compassion satisfaction and help them relieve the tension between biomedical, clinical competence versus compassionate, patient-centered care (19). It has been shown that in the workplace, supportive team culture, congruent practices and decision-making, and connections with patients and families can enable intensive care nurses to be compassionate. Outside the workplace, nurses' ability to be compassionate seems to depend on their values and lifestyle factors (20). Excessive workload, inadequate staffing and lack of value on

compassionate care have been identified as barriers to the delivery of compassionate care. It has been suggested that compassionate practice should not be an individual but a collective responsibility (21).

There is still a dearth of policies to introduce and promote compassionate leadership in health care (22). This study seeks to provide a trustworthy description of their experiences and expectations of compassionate leadership and compassion. The knowledge can be used to promote nurses' coping and wellbeing and to develop compassionate leadership in healthcare organizations.

Methods

Setting and Design

This qualitative survey was conducted at a central hospital in Finland. Data was collected in the early months of the COVID-19 pandemic, in March-April 2020, using a questionnaire based on a systematic literature review.

Participants

Participants were 50 nurses from intensive care and emergency departments of a central hospital. Most respondents were female (42 women, 7 men). The majority (57%) were experienced nurses (n=14 >30 years; 16% =30-21 years; 27% = 20-11 years). Only 12% had less than 2 years of experience.

Data Collection

Initially, all nurses (N = 192) in the intensive care and emergency departments were contacted via e-mail through the Hospital Press Officer. The potential participants received an e-mail

link to an online survey tool (Webropol). The voluntary nature and anonymity of the survey was stressed in the cover letter, to make sure that the participants did not perceive any undue influence caused by participating in the study. The low response rate (26%) may be associated with the COVID-19 pandemic and lack of staffing. In addition, online questionnaires may be more easily overlooked compared to paper surveys.

The questionnaire contained three background questions on participants' gender, department and nursing experience and the following open questions, based on a systematic literature review conducted by the researchers on leadership styles:

- (1) What does compassion mean in working life?
- (2) How is compassion expressed by leaders in working life?
- (3) How would you like leaders to express compassion in working life?
- (4) Which factors support the maintenance of compassion in working life?
- (5) Which factors hamper the maintenance of compassion at your work?

The term leader referred to the nurses' immediate supervisors, who were ward managers or assistant ward managers.

Data Analysis

Inductive content analysis was used to analyze the 27 pages of transcribed data (Times New Roman, font 12). The average word count for each question response by participant was 300-350 words. There was an average of 0.5 pages of transcribed data per participant, and 20-30 quotes per participant providing useful information. After reading through all the data several times the investigator, who conducted the analysis, concentrated on responses for each question separately. Original sentences and ideas that represented an answer to the research

questions picked out and stored in Word files. These utterances were reduced to core contents and the 68 reduced utterances grouped into categories representing similar contents. These categories were finally combined into higher level categories. The data was considered saturated when a great deal of similarity started to occur in the responses to open questions. When similar instances started to recur 8-10 times, the researchers became confident that the categories were saturated. Table 1 gives an example of how the analysis proceeded. (Insert Table 1 here)

Rigor

Study permission was obtained from the Administrative Nurse Leader of the Central Hospital, who was responsible for study permissions concerning research on nursing staff. The Administrative Nurse Leader had no dual roles that could have influenced nurses' decision to participate.

Participation was voluntary and anonymity was carefully protected. An online survey was used without participant names or email information. The Hospital District practice was to require formal ethics approval only for studies involving clients or patients, so none was obtained. The decision to respond to the questionnaire anonymously was regarded as informed consent. The research process was guided by recognized research ethical principles in accordance with the Declaration of Helsinki (23).

Some observations can be made on this study from the perspectives of transferability, credibility and confirmability. Careful reporting of the context, data collection and analysis increased the transferability of the findings. Transparent description of the analysis also enhanced credibility (24), along with nurses' personal experiences (25) through their original

contributions (26). Researcher triangulation was used to support the credibility of the results. After the preliminary analysis was conducted by one researcher, the other researcher read the analysis and compared it to the original data. An attempt was made to increase the confirmability of the findings by reporting all stages of the research process as carefully as possible. The researcher repeatedly returned to the original set of data to ensure that the interpretation was supported by evidence (27).

Results

Five categories emerged from the analysis as a response to the research questions:

- (1) Meaning of compassion experienced at the workplace
- (2) Compassion received from leaders
- (3) Expectations for compassionate leadership and needs for support
- (4) Factors maintaining compassion
- (5) Stress as a challenge to the maintenance of compassion

The five categories included two to four sub-categories, marked in bold. The results contain original quotes from the participants. No significant differences were observed between intensive care and emergency care nurses.

Compassion Experienced at the Workplace

In the nurses' essays, compassion emerged as a form of **social capital at the workplace**. The art of compassionate listening was emphasized as the most important element in this context. Compassion was also associated with a positive atmosphere, encouragement and open problem management. It was considered a core element of nursing. Compassion was also seen as a seedbed for empathy, mutual appreciation, respect and sense of community. Other

elements associated with a compassionate workplace included multiprofessional teamwork, positive learning experiences and constructive feedback.

The respondents recounted several positive consequences of compassion at the workplace. Help and compassion received from colleagues had reduced stress, enhanced wellbeing and increased the will to reciprocate the support. According to the participants, “*genuine encounters*” between colleagues and reciprocal caring had helped them cope with challenging situations. For example, the “*presence of compassion allows us to express various emotions. Your emotions are appreciated. The working community accepts your incompleteness, without “guilt-tripping”*” (P10). Compassion had made it possible to understand and learn from mistakes, and to accept colleagues as they were. Compassion and social support had also increased safety at the workplace. To quote some of the nurses on compassion:

It’s important to understand others, compassion creates safety in the working community (P3); It’s understanding and supporting colleagues in various situations (P6); workers appreciating their colleagues” (P7); It supports decision-making in nursing. Compassion helps to cope with psychological stress. You have the courage to talk about problems/ambiguous issues (P14).

Secondly, compassion experienced at the workplace had been associated with **compassion from leaders**, expressed as the leaders’ physical presence at the workplace. The importance of their participation in the daily routines was one of the major findings in this study. The participants described a compassionate leader as one who was easy to approach, listened to the employees and provided constructive feedback. A compassionate leader, according to the participants, was “*aware of what was going on at the workplace*”, assumed responsibility for sharing and forwarding information, and expressed interest in employees’ competence and coping. A compassionate leader was aware of the strains of shift work. To quote,

Compassion from the working community and supervisor creates safety and carries you. You know that whatever comes, you will receive compassion in the working community” (P16); ...the immediate supervisor of the working community appreciates the employees’ opinions and acts on them (P23), and A compassionate, easy-to-approach supervisor listens to the

employees, knows what is going on at the workplace, is interested in your competence and coping. They should be more present in the daily work (P13).

Third, a subcategory called **individualized compassion at the workplace** refers to fair and flexible allocation of work shifts and an understanding attitude towards employees' limitations and work-life balance challenges. According to the participants, this ideally meant work-time models tailored to employees' life situation. They wrote, "...*that everybody is taken into consideration as an individual, with their competencies and limitations*" (P5), and "*Compassionate understanding is the alpha and omega of this profession*" (P9).

Compassion in patient encounters was the last sub-category in this section. The participants indicated that compassion received from leaders and colleagues had been reproduced as empathic and genuine encounters with patients and family members. It had meant understanding the patient and family perspective and putting oneself into their position. In the essays, compassion was also associated with patient safety and with working as a competent professional "*for the best of the patient*". However, the participants also pointed out that compassion could be stressful; excessive understanding could be very exhausting. To exemplify,

I think compassion is an important part of nursing practice, I'm sure patients have confidence in the nurse and feel safer, when the patient is genuinely encountered (P13); Compassion is important, but it can also be exhausting, if you always fully identify with another person's emotional state. (P2).

Compassion Received from Leaders

As a response to the second item (How is compassion expressed by leaders in working life?), the participants had both positive and negative experiences to report. **The positive experiences** involved leaders, who were "*present*", empathic, understanding and easy to approach. Many participants stressed the importance of leaders listening to them.

Compassionate leaders were interested in supporting the coping of employees, for example by allocating shifts individually and accommodating private needs. They offered support to employees facing adversaries in their private lives.

The participants further described compassionate leaders as persons, who facilitated professional development. Such leaders provided “*occasional positive feedback*”, but “*did not demand too much*”. They involved their employees in development efforts and were open to divergent views. To quote, “*The supervisor is interested in your work and coping, listens to you, supports you and asks how they can help*” (P4), and “*...comes to say hello to the employees in the morning*” (P15).

In contrast, the majority of the contributions in this study dealt with **negative experiences** and lacking or random acts of compassion from the leaders. To quote two participants,

It is not expressed, I have a feeling that my supervisor doesn't know much about my work ...negative emotions are not allowed... (P10) and Pressure, too much responsibility and negative feedback decreased my coping. Lack of support from the supervisor, lack of interest, belittling and malice were really stressful (department and work history unknown).

These negative experiences had involved the feeling of not being heard. Leaders were described as distant and silent. Responsibilities were either being delegated or guidelines followed to the letter, which had led to “*management by criticism*”. Other experiences involved leaders’ impulsive decision-making and denial of problems addressed by employees. The leaders had not understood the nurses’ perspective and had seemed unaware of the strains of their work. Many nurses seemed to feel they had been left to fend for themselves without a choice. As one nurse put it, there was “*...a glaring lack of compassion for shift-workers*” (Department and work history unknown).

To sum up, there was great variation in the experiences depending on the leader and the nurse. To quote, “ *There are many supervisors in a big department. One makes nice small talk and that’s enough, another takes care of practical issues, and still another does not even say hello or answer any acute questions*” (P19).

Expectations for Compassionate leadership and Needs for Support

The third category in the findings contained the nurses’ expectations for compassion and their needs for support from supervisors. These needs and expectations were twofold: **psychosocial** and **psychophysical**.

The **psychosocial** expectations and needs included the need to be given time, to be listened to and to be involved in open discussion on emotions and current workplace issues. The nurses wanted the leaders to express interest in them as persons. They wished for trust and co-operation between leaders and employees and expressed the need to be equally appreciated.

Personal feedback and encouragement in stressful situations was considered important. The nurses wished that during the Covid-19 pandemic, the leaders had stopped to reflect on how well the staff had coped with the challenge, and what could still be developed. One of the participants wrote, “ *...that they would notice that we have once again managed a difficult time.*” (P17). The nurses hoped for understanding and time to adjust to the constant changes. As one of the participants put it, “ *...to understand that it takes time to adjust to the changing working environment, you can’t master everything at once*” (P7). Some nurses also wished that in case of conflicts, more time was allocated for listening to all parties before any conclusions were reached. To quote, “ *underachieving management, no comments, talking about unfinished issues, going public about changes and decisions without informing staff, all*

that decreases compassion in the working community” (P11). In short, the participants wished for the application of “*positive psychology*”. Many of them would have appreciated a greater amount of positive and constructive feedback, mutual listening and genuine dialogue.

The **psychophysical** expectations and needs involved the physical presence and availability of the leaders. Large departments typically had several supervisors. The participants suggested that permanent supervisors would be better aware of the daily routines and situations and thus better prepared to offer support. Face-to-face performance appraisals were considered as useful opportunities to express one’s wishes and objectives for professional development. One participant wrote, “*It would be good if the boss showed up in the working community and understood the daily routines and expressed some interest in the work of the employees and department*” (P18).

Factors Maintaining Compassion

Three sets of factors were found to maintain compassion at the workplace. They were labeled **social skills**, **resilience skills** and **individual skills**.

Social skills here refers to pleasant and kind behavior in the daily working life, such as friendly greetings, smiling and listening to each other. The nurses wanted to be seen and appreciated beyond their work roles. One of the nurses wrote, “*easy to approach, smiling, greeting, questions like ‘how are you doing’*” (P1).

The results further revealed the importance of **resilience skills**. Being united by common goals and mutual support, and succeeding in dealing with difficult situations had helped participants maintain compassion at the workplace. Many nurses seemed to find their work

meaningful and appreciated the possibility “*to belong*”. Personal experience of compassionate support had increased their will to support their colleagues.

Finally, the sub-category **individual skills** refers to a person’s ethical values, character and other individual attributes, which support the maintenance of compassion at the workplace. According to some participants, employees themselves were also responsible for their coping and work ability. Personal recovery methods, time spent with family and friends, and other ways of improving one’s work-life balance had helped them maintain a compassionate attitude. One of the nurses wrote, “*Attention given to wellbeing, when you can cope better, it’s easier to give compassion and support to others*” (P11).

Stress as a Challenge to the Maintenance of Compassion

Four sets of stressful factors had hampered the maintenance of compassion at the workplace. They involved **physical, psychological and social factors**, and **factors related to competencies and responsibilities**. The difference between psychological and social factors here was that in the first, the emphasis was on inner, individual experiences, whereas the latter concerned interaction and communication.

Among **physical factors**, the size of the workplace had been a major stressor. The participants had found it difficult to maintain compassion at a workplace with a great number of employees and high staff turnover. In addition, lack of instruments and equipment was mentioned.

Many **psychological factors** were found to be obstacles to the maintenance of compassion at the workplace. Hurry and stress were commonly mentioned. Stress was frequently seen as a

result of a "*bad working atmosphere*", characterized by unfair treatment of employees, egoism, jealousy and bitterness. Negative feedback, excessive responsibility and being "pressured" were also mentioned. Some nurses reported fear of their superiors' reactions and many felt that they had not been supported by their colleagues, leaders or the organization. The high staff turnover had resulted in not knowing one's colleagues, and in the feeling of being dispensable. One participant described temporary staff as follows, "...*passers-by exhausting your compassion/empathy, although it's really not their fault...*" (P4). On the other hand, some participants saw "*the constant complaining*" and dissatisfaction, and the nurses' habit of "*using hurry as an excuse*" as a negative factor for the development of compassion.

Third, the participants described **factors related to competencies and responsibilities**, which had negatively affected the maintenance of compassion. Some of the nurses had suffered from insecurity due to insufficient competencies. For example, "*If there are many things at the same time that affect your work, like hurry, lack of resources – of workforce, instruments, equipment- and if you don't have the knowhow needed for the job*" (P6). Other nurses, in contrast, described the opposite situation; they had felt the burden of having to support inexperienced or inept colleagues. One of them wrote, "...*constantly having to deal with inexperienced staff*" (P8). In addition, the participants mentioned duties not matching their qualifications or tasks being reduced to routines.

Last, some **social factors** were mentioned as obstacles to the maintenance of compassion. Partly overlapping with the findings presented under psychological factors, the participants described a poor working atmosphere, negative attitudes and lack of empathy from colleagues or leaders, and "*unresolved issues*" at the workplace. Having been excluded and workplace bullying were indicated. To quote one of the nurses, "*Cliques, and excluding new workers ...*"

(P7). Other problems described involved "*lack of manners*" and difficulties in communication, especially lack of dialogue and listening. Poor leadership was directly or indirectly indicated. It was suggested that various regulations, produced by hierarchies and bureaucracy had increased the distance between leaders and nurses.

Discussion

This qualitative study brings together nurses' experiences and expectations for compassion and compassionate leadership in intensive care and emergency departments. The nurses reported a variety of positive experiences of compassion at the workplace, although the emphasis in this study seemed to be on the absence of compassion, especially as regards leadership. Part of the participants described being supported by colleagues and leaders, being seen beyond their professional roles and having their individual needs taken into consideration. Others, in contrast, reported indifference and unfair treatment. The maintenance of compassion was found challenging due to high staff turnover, stress and lacking staff competencies. This finding is in agreement with earlier research (21).

As in earlier research (19), the nurses reported a pressing need for emotionally intelligent and compassionate nurse leadership, which in healthcare literature have been linked with empowerment processes and positive organizational outcomes (28, 29). As suggested in a large international survey, obstacles to compassionate leadership vary across countries. They may be related to the leaders' personal characteristics and experiences, or they may be system or staff-related (22). Excessive workload, inadequate staffing and lack of value on compassionate care make it harder to cultivate compassion (21). Some nurses in this study seemed to think that compassionate leadership was something that could be learnt, whereas other saw it as a trait. According to Ellis, for example (30), leadership knowledge and skills

can be taught and learned. He demonstrated compassionate and transformational leadership as pertinent to nursing practice today.

In the nurses' essays compassion was discussed from various perspectives, as expressed between colleagues, received from leaders and passed on to patients and family members. There was little elaboration on self-care, and what was lacking completely, was reference to self-compassion. Both can be seen as a foundation for compassionate care (31).

The results imply that compassion received from leaders and colleagues is reproduced in the patient contacts, which can increase patients' feeling of safety. Earlier research from Edmondson (32) has shown that an association exists between feeling safe in the clinical working environment and having received compassion from the leader. Psychological safety, or a shared belief that risk taking is acceptable at work, has positive outcomes for commitment, creativity, decision-making and the overall performance in the organization (32). Psychological safety and ability to speak up freely to higher status individuals have been shown to predict engagement in quality improvement work and mediate the relationship between engagement and leader inclusiveness (words and deeds exhibited by leaders that invite and appreciate employee contributions) (33). Similarly, a recent theoretical framework for improving interpersonal relationships in the workplace (34) recommends inclusiveness and open and frequent communication for nurse leaders to establish psychologically safe relationships and better interprofessional collaboration (34). In an ideal case, a chain of compassion and psychological safety could be created between nurse leaders, nurses and patients, leading to positive outcomes for the care quality. Such a working environment would allow both leaders and staff members be seen as valuable but vulnerable human beings

beyond their professional roles, as described by Schuck (14) and de Zulueta (15), and the cultivation of compassionate practice could be seen as a collective responsibility (21).

In agreement with other research, it can be recommended that leaders support their staff through education, training and policy development (35) and through the promotion of resilience and problem-focused and emotion-focused strategies (36). Participatory and simulation-based learning methods, which involve shared reflection, are suggested for nurse manager education. Simulations have been proved effective in learning interaction, teamwork and leadership skills (37, 38). However, additional research is required on the effectiveness of these methods on developing compassion and emotional intelligence. The relationship between leadership style and psychological safety is also worth looking into. One question that arises from the results concerns the differentiation between empathy, sympathy and compassion. Professional compassion “misunderstood”, combined with high expectations for nursing outcomes, can easily lead to exhaustion. Both nurses and leaders might benefit from reflection on the differences between compassion, empathy and sympathy, as in Schantz (6). As proposed in a critical review on compassion, it is important to make use of the emergent literature about how compassion as a practice and moral virtue can be sustained in environments dominated by efficiency and rationalization discourses (39).

Strengths and Limitations

This is the first research on nurses’ experiences of compassionate leadership in Finland. All staff members in a hospital had an equal opportunity to participate in the study. The research process was transparent and accurate and the description of the analysis clear, illustrated by a table. The results can be useful for leadership development in national and possibly international settings.

As the topic was sensitive, the participants were asked to describe their experiences anonymously through an online tool, rather than discuss them face-to-face with a researcher. However, conducting interviews could have enabled a deeper understanding of the nurses' experiences. Another limitation is that one researcher analyzed the data, which can cause some bias into the qualitative analysis. An effort was made to mitigate bias by a thorough analysis, repeated return to the original data and discussion with the other researcher, who compared the results to the original data.

Conclusions

Compassion seems essential for nurses' coping and wellbeing in clinical nursing characterized by constant changes and critical situations. Leaders have a crucial role in promoting a compassionate atmosphere. Their work starts with awareness of how important psychological safety and self-expression are for collaboration, commitment and quality care. Leaders can express compassion by being physically present and by fostering an open dialogue. Investing on self-compassion and self-care is important for both nurse leaders and staff. Compassion received from leaders and colleagues can be reproduced in patient contacts, which can increase patients' psychological safety. Participatory and simulation-based learning methods are recommended for the development of compassion and compassionate leadership skills. Both nurses and leaders might benefit from reflection and discussion on the differences between compassion, empathy and sympathy.

List of Abbreviations

COVID-19 Coronavirus 2019

ED Emergency department

ICU	Intensive care unit
P	Participant

Declarations

Ethics Approval and Consent to Participate

Following the regulations and general policy of the Central Hospital for studies not involving patients or clients, study permission was obtained from the Administrative Nurse Leader of the Hospital. The Hospital District did not require ethics approval for the study, as it did not involve clients or patients. The decision to respond to the questionnaire anonymously was regarded as informed consent. The research process was guided by recognized research ethical principles in accordance with the Declaration of Helsinki.

Data Accessibility Statement

The material is in Finnish language. It is stored and eliminated according to the guidelines of the Hospital District, where it was collected. To request the data, please contact the Hospital District.

Conflict of Interests Declaration

The authors declare that they have no competing interests.

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Authors' Contributions

Author X collected the data. X and author Y conducted the analysis and Y wrote the manuscript. Both authors read and approved the manuscript.

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Table 1. Inductive content analysis (example)

Original expression	Reduced expression	Sub-category	Category
It means that the superior gives you time	The need to be given time	Psychosocial expectations and needs	Expectations for compassionate leadership and needs for support
Superiors demonstrate that they give you time by stopping beside you			
It would mean that you are genuinely listened to, not just pretending to listen	The need to be listened to		
I expect open discussion on emotions and current concerns and situations at the workplace	The need to be involved in open discussion on emotions and current situations at the workplace		
Superiors show us that they are interested in us as individuals	The need to be seen as individuals		
One would really hope and expect genuine trust both sides and reciprocal co-operation	The wish to have trust and co-operation between leaders and employees		
I have just little work experience and I wish everybody would equally receive appreciation, attention, support and encouragement in the everyday work.	The need to be equally appreciated, supported and encouraged		
My work history is still short, and I hope for personal feedback and encouragement, because I am still insecure and experience a lot of stress in acute and demanding situations.	The need to receive personal feedback and encouragement in stressful situations		
...to understand that it takes time to adjust to the changing working environment, you can't master everything at once	The need for understanding and time to adjust to the constant changes		
I do hope that our superiors would show it and tell that they care for us, and tell if they are worried	The need for immediate supervisors to act as advocates genuinely concerned about nurses' coping	Psychosocial expectations and needs	Expectations for compassionate leadership and needs for support
In my opinion, the superiors should demonstrate that they care, not just stay in the office.			
...that they would notice that we have once again managed a difficult time	The wish that during the Covid-19 pandemic, the leaders had stopped to		

	reflect on the past and development needs		
Sometimes there is no sign of equal treatment, I wish that they listened to all parties when there is a conflict situation, not just the favorites, before it is decided how to reach a solution.	The wish that more time was allocated for listening to all parties before any conclusions were reached in conflict situations.		

