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Understanding the concept of compassion from the perspectives of nurses

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Abstract

Background: The high level of satisfaction of users of a health service is largely due to the fact that they receive excellent care from healthcare professionals. Compassionate care is an essential component of excellent care. But what do nurses understand compassion to be?

Research objectives: To analyse the concept of compassion from the perspective of nurses in the Andalusian Public Health System, Spain.

Research design: This is a qualitative study following the grounded theory model. Four focus groups and 25 in-depth interviews were conducted.

Participants and research context: A total of 68 nursing professionals working in the Andalusian Public Health System (Spain) participated. Theoretical sampling was used, with participants being recruited using the snowball technique.

Ethical considerations: This research was approved by the Research Ethics Committee of the Centro-Almería Health District (CEICA 27/9/17).

Findings: From the analysis of the data, four themes emerged that helped to understand the concept of compassion according to nurses: 'Negative perception of the term compassion', 'Compassion and empathy as synonyms', 'Beyond empathy', and 'Effects of having a compassionate attitude'.

Discussion: Nurses perceive the concept of compassion differently to each other and even contradictorily. This concept is imbued with cultural elements, which adds confusion to understanding it, and is even perceived as something negative similar to pity.

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Conclusion: Nurses confuse the concepts of empathy and compassion as if they were synonymous. Before considering training in compassion for healthcare professionals, it is essential to clarify the concept of compassion through educational interventions.

Keywords
Compassion, empathy, grounded theory, nurses, nursing care

Introduction

Care is an intrinsic feature of the nursing profession;[1] however, in order to provide it in a holistic way it must be coupled with compassion.[2] Care and compassion are inherent to the nursing profession, and practising it is the duty of nurses.[3–5] In recent studies, good nurses are defined as having attributes such as responsibility, compassion, honesty, and advocacy.[6] Focusing on compassion, it is defined as a set of specific virtues such as honesty, kindness, and flexibility, and actions such as touching, being attentive, or smiling.[7] Even the Code of Ethics for Nurses includes compassion as a professional value.[8]

Background

Etymologically, the term compassion comes from the Latin word *cumpassio*, from *com* (with) and *pati* (to suffer), and *pati* comes from a Greek verb meaning 'to suffer with, to suffer together, to feel for'.[9,10] In philosophical writings, the concept of compassion also appears as something inherent to and inseparable from human beings, being identified as a shared and ineffective sadness.[11,12] Compassion is even equated with commiseration and is described as the shining path through which the boundary between the self and others is erased; compassion would therefore be a moral act of union and solidarity.[11] In more recent times, various authors defend, albeit from different perspectives, compassion as a quality inherent to human beings that enables us to reach beyond ourselves in order to share the suffering of others and try to transform that reality.[12] However, the most accepted and currently used definition of compassion in the field of mental health and research would be the following: compassion is the sensitivity to one's own suffering and the suffering of others, together with the commitment to prevent and alleviate said suffering.[13]

We see how the meaning of the term compassion has been a philosophical concern throughout history, but its understanding also stems from religious ideologies and is the foundation of spiritual and ethical traditions.[7,10] Within this religious sphere, it is possible to assert that, in Christianity, compassion is valued as an emotion that elevates the self,[14] and anyone can become the recipient of compassion and mercy according to the evangelical principles of love for others as well as for oneself.[7,15] In Buddhism, the ideal of openness to others, especially to their suffering, is maintained, and compassion is encouraged as one of the four immeasurable states of mind.[15] Islamic scripture also supports compassionate care in all aspects, and states that health workers should be compassionate and show no signs of fatigue.[16] In any case, at present, compassion has negative religious or cultural connotations for some professionals, as they relate it to pity or feeling sorry for the suffering of others.[17]

In spite of what has been described so far, in the literature, sometimes, compassion appears as a quality close to empathy, although they are not actually equivalent.[18] Empathy may be defined as the ability to understand and participate in someone else's emotional reality and feelings.[19] However, empathy is the indirect experience of someone else's emotions, but it does not necessarily entail a response to their suffering, and it does not involve the will to act. Compassion, in contrast, goes one step further and also includes the motivation to take some action to alleviate the perceived suffering by strengthening the

awareness of our interdependence and reciprocity.[20–22] In Wispé's words, empathy involves becoming aware of the situation observed, whereas compassion would correspond to the generation of emotional responses.[23]

This whole philosophical and religious journey of the concept of compassion is what leads us to the currently accepted definition of compassion in the field of health sciences.[7,10,18] Compassion is understood as openness and sensitivity to suffering, along with the desire and motivation to relieve it.[13,24] Currently, certain sciences such as bioethics, nursing, medical research, neuroscience, social psychology, contemplative sciences, and medical anthropology, among others, have taken an interest in this concept.[5] What is clear is that compassion is now a key aspect of high-quality healthcare.[4,13] Compassion has been linked to nurses' health and emotional well-being.[25] It also brings benefits to users and healthcare organisations alike.[26,27] It is well known that compassionate care improves therapeutic adherence, reduces recovery time, and decreases the number of hospitalisations, all of which have an impact on healthcare expenditure.[28,29] Patients' immune response increases as a result of compassionate care and their need for end-of-life intensive care diminishes, as does post-traumatic stress in emergency situations.[30–32] What, however, does compassion mean to nurses today? Understanding what compassion means to nurses provides a foundation for training programmes designed to cultivate compassion,[7] increasing levels of compassion satisfaction among nurses and improving the quality of the care they provide within the healthcare system.[33] A study was proposed to analyse and understand the concept of compassion from the perspective of nurses working in the Andalusian Public Health System (Spain).

Methods

A qualitative study based on the grounded theory model was conducted following the guidelines set out by Glasser and Strauss.[34] They argue that theory should be developed on the basis of the available data (a bottom-up approach) using an inductive method. Our primary objective was to develop a theory to explain the study phenomenon: the concept of 'compassion'. To this end, the documents were combined to create a hermeneutic unit, which was then used to analyse quotes, codes, and networks. As the research progressed, emerging elements of analysis that were directly or indirectly related to the study phenomenon were incorporated. These relationships were structured into semantic networks and were gradually categorised to gain a better understanding of the phenomenon. This analytical process was repeated until theoretical saturation was reached, that is, when the incorporation of new data did not provide relevant information for existing categories or when new categories or codes were no longer discovered. This grounded theory analysis employed the constant comparative method, in which similarities and differences identified in the data are constantly compared. Our aim was to detect recurring patterns using ATLAS.Ti 8, a CAQDAS (computer-assisted/aided qualitative data analysis software) based on grounded theory that is designed to help researchers save time, facilitate complex processes, and make the review of analytical processes more flexible.

Participants

The study population consisted of healthcare professionals from the Andalusian Public Health System (Spain). Informants were selected using an intentional sampling method with the snowball technique.[35] This technique made it possible to conveniently select the informants who could provide the most information based on the objective of this study. The number of participants required was determined by the principle of theoretical saturation, according to which no new relevant data are obtained even if the sample size is further increased.[34,36] The inclusion criterion was being a nursing professional currently working in close contact with patients. The exclusion criteria were: professionals who were on sick leave, working in

Table 1. Sociodemographic characteristics of the participants (*n*).

	FGSs ($n = 43$)	IDIs ($n = 25$)
Gender		
Women	37	18
Men	6	7
Age (years)		
<40	2	3
41–50	18	13
>51	23	9
Healthcare setting		
Hospital care	32	16
Primary care	12	9
Employment status		
Casual	1	2
Temporary or long-term	7	7
Statutory or permanent	35	16
Work experience (years)		
<20	6	11
21–30	27	9
>31	6	5

FGSs: focus group sessions; IDIs: in-depth interviews.

special services, holding management positions in the healthcare administration, and/or who refused to participate in the research.

Participants were selected with the assistance of the heads of the healthcare centres (Directors and Care Coordinators), who met with the researchers beforehand. Once the participants had been selected, they were invited to participate in the study. To this end, they were sent a cover letter by email inviting them to participate. Constant feedback and coordination between the researchers and heads of healthcare were maintained throughout the recruitment period. A total of 68 informants participated, 43 in focus group sessions (FGSs) and 25 in-depth interviews (IDIs). The mean age of the participants was 44.96 years ($SD = 6.61$). Table 1 describes the main sociodemographic and occupational characteristics of the participants.

Data collection

During 2019, 25 IDIs and 4 FGSs were conducted by the researchers in 'neutral' locations (away from the healthcare facilities). The interviewers were trained to ensure maximum homogeneity in the conduct of the interviews. The FGSs were held first, followed by the IDIs. By applying the different data collection techniques in this order, researchers were able to use the IDIs to delve deeper into aspects that had emerged during the FGSs but had been insufficiently explored. This order also made it easier for interviewees to present their discourses without the potential influence of group interaction. Each FGS had a duration of 90 min, in which two researchers participated, one of them by stimulating the group dynamics and the other one by recording any observations and incidents that arose during the development of each FGS. Each session began with the question 'What do you understand by compassion or compassionate care?' Subsequently, the IDIs were conducted by one researcher, with an average duration of approximately 45–60 min. The IDIs and the FGSs were recorded on audio for subsequent transcription and analysis by the research team.

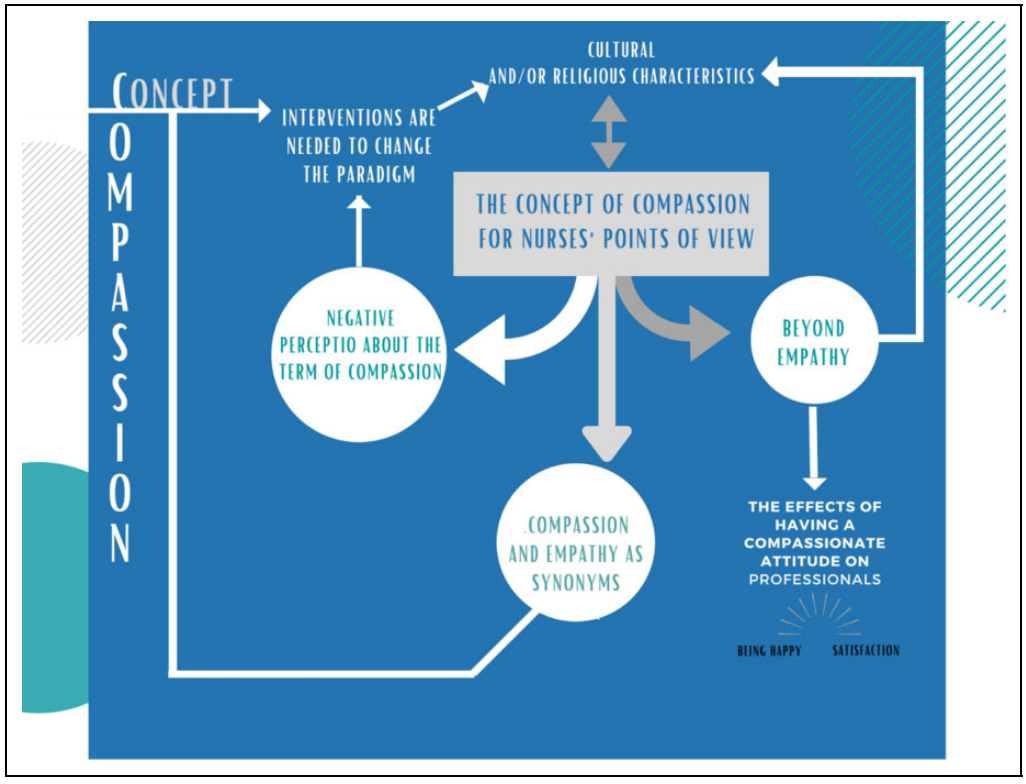

Figure 1. The concept of compassion for Andalusian nurses.

Data analysis

The constant comparison method was used for data analysis. This method contributes to the development of a grounded theory. The coding process consisted of three phases: open, axial, and selective.[34,36] During the open coding, after a reading and re-reading of the interviewees' discourses, in-vivo codes were generated. After a process of comparing similarities and differences between codes, the codes were grouped into broader categories or subcategories. Subsequently, during the axial coding, an active and systematic search for the relationships between the categories was conducted. This led to the formulation of a hypothesis that raised the following question: 'What does compassion mean for nurses?' The answers to this question were organised into four main categories: 'Negative perception of the term compassion', 'Compassion and empathy as synonyms', 'Beyond empathy' and 'The effects of having a compassionate attitude on professionals'. During selective coding, a conceptual or theoretical relationship was established between the different categories. A core category was identified which, due to its centrality, explained and gave meaning to all the data and their relationships, thus generating a grounded theory. Finally, the categories created in the previous steps were connected using a concept diagram (Figure 1).

Rigour

The constant comparison method of analysis of the grounded theory itself ensures sufficient scientific rigour. Nevertheless, in order to strengthen this aspect, different procedures have been implemented, such

Table 2. Themes, sub-themes, and units of meaning derived from data analysis.

Theme	Sub-theme	Code
Negative perception of the term compassion	Compassion understood as pity for the suffering of others	Feeling sorry, pity, poverty
	Compassion as a religious expression	Religion, beliefs, values
	The burden of suffering for and with others	Experiencing suffering, suffering for others
Compassion and empathy as synonyms	Putting oneself in the patient's shoes	Putting oneself in other people's shoes, similar to empathy, being on the other side
	Understanding others' experiences	Why someone is suffering, understanding
Beyond empathy	Being present	Presence, keeping someone company, spiritual openness
	Shared vulnerability	It could happen to me, vulnerability, fragility, equality
	Desire to alleviate suffering	Helping, freeing, alleviating
The effects of having a compassionate attitude on professionals	The satisfaction of keeping someone who is suffering company	Learning, Satisfaction of helping
	Being happy	Seeking the happiness of others, A way of relating

as the triangulation of different techniques, participants, and researchers, the reflexiveness of the researchers, and the relevance of the results.[37]

Ethical considerations

This research was approved by the Research Ethics Committee of the Centro-Almería Health District (CEICA 27/9/17). Participants were informed of the purpose of the study and their written consent was obtained. The confidentiality and anonymity of the participants were preserved at all times, their data were protected in accordance with the Spanish regulations in force, and the principles of the Helsinki Declaration were observed.

Results

From the analysis of the data, four themes emerged that helped to understand the concept of compassion according to nurses (See graphically in Table 2):

Negative perception of the term compassion

There is a large repertoire of discourses expressing, either explicitly or implicitly, a negative perception of the word compassion. This way of viewing the term is related to both its identification with feelings of sorrow or pity, and to a conception linked to religious culture that generates an expression of rejection.

> I just don't like that word. (IDI, 12:4)

> The thing is that I, regarding compassion and charity stuff . . . I prefer seeing actions rather than charity, so [compassion] is not something I like. (IDI 27:4)

Compassion understood as pity for the suffering of others. There are plenty of discourses where the term compassion is equated with feeling pity or sorrow, and these feelings are considered to establish a power differential between the two parties involved. Feeling pity or sorry is perceived as an obstacle to understanding the situation of those who suffer.

There is also the idea that, if compassion is understood as something similar to pity, it should not be an element to be cultivated in interpersonal relationships with patients, as it must not be pleasant or positive for sick people to feel that their healthcare professionals are feeling sorry for them:

> Yeah, that's the definition now. I understand compassion as feeling sorry for someone: 'Oh, poor thing, I feel sorry for you!' (IDI 15:5)

> I wouldn't want someone to feel sorry for me if compassion means feeling sorry, and I don't think patients like to be pitied. (IDI 9:8)

In contrast, there are informants who react to this pity-related conception by expressing ignorance of the term, but also by stating with certainty that compassion and pity are not the same thing. Rather, they understand compassion as something closer to empathy, as a feeling of joy for the good of others or something that can be good:

> Pity never, not pity . . . For me it's just that, rather than compassion, it's more like empathy or a mixture of the two that we can use: we stick by their side and I see it, you know . . . it's respect and empathy, for me that's what [compassion] is. (IDI 11:5)

> I don't understand it as pity or pitying someone, rather I understand it as a good thing. (IDI 20:8)

Compassion as a religious expression. In some discourses, this way of conceiving compassion is identified with a term of religious origin which, in the specific socio-cultural context in which this research was conducted, would be typical of the Christian religion. As it is expressed, it may be understood as a value or a virtue of the private sphere linked to one's own personal beliefs:

> The feeling you get when someone tells you 'compassion' is 'what are you talking about?' It sounds like a concept from a religion course . . . something that is not professional, that is more linked to your beliefs and your values as an individual that has almost nothing to do with professionalism. (IDI 6:3)

> It's a term I kind of associate with religion, perhaps. (IDI 25:6)

The burden of suffering for and with others. Some informants feel that compassion means suffering for others, which means that practising compassion is taking on some of the suffering of the individual being cared for. Professionals would put themselves in the patients' shoes and suffer alongside them. From this conception, to be compassionate would always bring a dose of additional suffering in each care situation:

> I think it's suffering for others. (FGS 2:23)

> To be able to put yourself in their shoes and to be, at the same time, able to suffer with them and to put yourself in their shoes, in short. (IDI 29:5)

Compassion and empathy as synonyms

The conceptual union of these two terms is present in most of the informants' discourses, which means that this was the idea that was most extensively discussed by the participants in the different techniques of the

study. It may be safe to say that, in most cases, nurses find it quite difficult to conceptualise compassion, but they understand that it is undoubtedly very similar to what they consider to be empathy. For this reason, when defining compassion, they use the word empathy or their own conceptual definition: understanding others, putting themselves in their shoes, understanding their situation, and so on.

> Yes, of course, it's understanding them, it's like empathy. (FGS 11:1)
>
> . . . what a difficult term; to me, compassion . . . the word empathy comes to mind; maybe I don't know how to define compassion as such, but empathy comes to mind. (IDI 21:1)

Putting oneself in the patient's shoes. Most informants understand that acting with compassion is precisely putting oneself in the shoes of the individual who is suffering 'as if I were the other'. This implies, first, that one recognises oneself in a position of equality, of symmetry; and second, it implies putting oneself in motion, moving from one place to another, from one existential position to another, approaching the lived experience of suffering the other individual is going through:

> You have to stand on the other side of the bed; you have to treat the sick, at least as I understand it, as you would want to be treated. (IDI 24:28)
>
> I think it's putting myself in the shoes of the person who's suffering, putting myself in their shoes. I believe that having compassion is putting yourself in the person's shoes. (IDI 31:1)

Understanding others' experiences. The informants voiced that being compassionate is also understanding others. One can put oneself in someone else's shoes and still sometimes fail to understand their feelings, ideas, and thoughts. It takes considerable effort to step away from oneself and one's own personal experience in order to come to a deeper understanding of what is going on inside the other person's head and why. Moreover, it cannot be limited to a particular moment in time, since human behaviours find meaning in biographical context. Nurses, as professionals specialising in human responses, have to strive to deeply understand the individuals they care for and have knowledge of not only their biology, but also of the their life experiences:

> I just think that if I don't put myself in the other person's shoes, I won't be able to understand them, and if I don't understand them, I won't be able to help them . . . (FGS 31:14)
>
> So I always try to think: let's see, this patient has this [illness], and this is his family situation, what would I do? Yes, that's how I would be thinking. Is he more demanding? Yes, but why? Then I always try to analyse what has lead the patient to react like this. (IDI 11:3)

Beyond empathy

Some informants perceive compassion as being more than just empathy, and approach the concept by adding different nuances that complete and enrich it in such a way that we could say that, starting from empathy, what they describe is much more than empathy. Among the attributes that they add to the concept are presence and openness, the paradigm of shared vulnerability, and a deep desire to alleviate suffering.

Being present. Based on the way the informants spoke to us, presence is much more than just being there. The nursing intervention 'Presence' (NIC: 5340) is an intervention of a cross-sectional nature, loaded with professional knowledge and skills. Informants describe it as a necessary compassionate trait that encompasses openness and makes keeping company possible:

> However, I understand compassion as presence, as keeping company, as being with someone through what is most likely an important life experience for them and when they are most likely looking for something more than advice or a technique or a treatment; they are looking for someone to be present with them, it's a spiritual opening. (IDI 20:7)

> But when the process comes to a close in a certain way, and you've been there and you've kept them company, and you've nursed, you've put yourself in a strong position. (FGS 26:29)

Shared vulnerability. Another thing upon which the informants elaborate as an aspect of compassion is the idea that all people share fragility as a basic component of being human. This trait can help us as professionals to place ourselves on an equal footing where we share the same vulnerability, providing the basis for the development of compassion:

> Making sure I stay grounded in reality every day and knowing that I am a person anything could happen to at any time, and seeing them, hearing what others say, and [knowing that] it can happen to me. (IDI 19:15)

> . . . all those things that we don't notice when we are on the other side; when you are on the side of the one who is suffering, you become perfectly aware. I think you can never lose that perspective of vulnerability. (IDI 29:23)

Desire to alleviate suffering. A key element that informants include in the concept of compassion is the desire to alleviate suffering. This involves an inner movement that is not only present on an intellectual or emotional level, but also guides behaviour (in this case, that of professionals) and involves motivation and commitment:

> That's what compassion is to me, feeling the need to relieve my patient of suffering. (IDI 16:12)

> For me, compassion is helping, it is diminishing the suffering a little, alleviating it, being there. (IDI 32:2)

The effects of having a compassionate attitude on professionals

Informants who express and understand the concept of, we found informants who reported feeling lucky to have the possibility of being in contact with people who are suffering. As they say, being there when someone is suffering provides them with a great learning experience for their own present and future. They also find great satisfaction in being able to help in these situations and they understand that this trait must be something common in nursing professionals:

> First, I feel lucky to be in contact with people who are suffering; I'm going to learn a lot from these people, they are going to be teaching me [how to care] for other people, so that I can know how one might suffer. (IDI 26:6)

> Of course, for me, compassion is recognising the suffering of others and being able to help them, isn't it? Something like that . . . It's a beautiful thing and a trait us nurses have or should have. (IDI 17:8)

Being happy. The ability to be present while having the courage not to run away and the genuine desire to relieve suffering is experienced as a happiness-giving way of life. In the experience of some of the informants, being compassionate brings happiness, and not only in the workplace. One way or another, this extends to the rest of the professional's life:

> One way of living compassion, as I see it, is in my work . . . it's how I relate to others . . . if you live like that you're happy, and if you live differently, well you're not, and I'm trying to be happy; it's very easy if you think more about others than about yourself. (IDI 22:1)

> It's like when [their] relatives tell you 'I have inner peace because I know that [he or she] is gone but didn't suffer'; it gives me inner peace when I know that patients, people, are gone and I have been able to be there and I have been able to lend a hand. It makes me feel happy. (FGS 26:28)

Discussion

The analysis of the results revealed different conceptual representations of the word compassion among nursing professionals. The concept of compassion is considered to be a behavioural ideal in the healthcare professions[38] and is linked to the values of health practice.[39] However, in exploring the meaning compassion has for nurses in our research, different and even contradictory ways of perceiving it have been voiced. This difficulty in conceptualising compassion is also imbued with cultural elements[7] that have generated a very broad and sometimes even contradictory repertoire of meanings for the term. Thus, sometimes informants express confusion, ignorance, or rejection of the term in their discourses, and other times they make a very positive assessment of the development and implementation of compassion in care practice. In fact, in a study conducted in Canada,[20] it was determined that further studies were needed to explore the subtle but important cultural differences when defining compassion.

In the cultural and social context in which the research takes place, a large proportion of the nursing professionals interviewed perceived compassion in a negative way. In other words, compassion is related to pity for the patient and, as in other studies, it was found that pity and commiseration are perceived as synonymous with compassion.[40–42]

In addition, a worldwide study revealed differences in a number of components and actions in the perception of compassion.[10] In this study, a Spanish participant agreed with some of our professionals in rejecting the term compassion because he related it to religious beliefs. This term has been linked for decades to specific cultural values, norms, or practices that are currently outside of what is considered to be professionalism.[43]

On the next level down, compassion is defined in most discourses using the concept of empathy as if they were synonyms. The literature, however, clearly distinguishes between the two, both in their meaning and in the effects they can have for professionals when developing them.[44,45] It is thus necessary to devise precise definitions and to consider the concepts of empathy and compassion to be vital to establishing the conceptual basis for the teaching, knowledge, and training of compassion in the practice of care.[23]

Continuing to the following level of depth, we find some discourses that conceive of compassion as going 'beyond' empathy. This means that, even though they do not have a clear idea of what compassion really is, they sense that it is not only limited to empathy. The intentional and conscious practice of compassion is characterised by interventions that may be viewed as something beyond the usual role of nurses.[20]

In addition, for a minority of the professionals in our study, compassion brings with it a desire to alleviate the suffering of patients. This concept of compassion coincides with the findings of several systematic reviews.[3,9] In these reviews, two conditions for compassion are described: the presence of a person suffering and the presence of another person to alleviate that suffering.[9] Sinclair defines compassion as the sensitivity exhibited to understand someone else's suffering coupled with the willingness to help and promote that person's wellbeing in order to relieve them of that suffering.[46] Presence, openness, the paradigm of shared vulnerability, and a deep desire to alleviate suffering are prominent elements within the construct of compassion. Presence as a constituent element of compassion is evident in other studies[47] where the data support the important role of establishing close connections with patients in providing compassionate care.

Concurring with Smith, some informants reported feeling fortunate to be in contact with individuals who are suffering, which brings them an inner sense of happiness.[20] In this study, the informants who valued compassion in a positive light are a minority. However, these were the ones who, from a deeper view of the

concept, recognised that compassion incorporates the attribute of satisfaction or happiness. The available literature suggests that compassion, when exercised under appropriate conditions, is beneficial for both professionals and patients.[3,10,33,35,48] However, we did not find any qualitative studies from the point of view of professionals that include this positive aspect. This is an obstacle to nurses being motivated to cultivate and train for compassion. For this reason, the results of this research suggest that it is necessary to work on changing the conceptual and symbolic repertoire of professionals regarding compassion in our setting. Interventions are needed to change the paradigm of compassion in our context and to promote both the motivation and the desire to cultivate it based on the conviction that compassion provides a higher level of satisfaction in professionals who develop it and benefits the patients and families of patients who receive it.

Given the importance of cultural aspects in defining compassion, one of the limitations of this research lies in the fact that certain cultural and religious variables were not collected from participants, which would have enriched our analysis. One of the strengths of the study, however, is that we have developed a conceptual framework for training programmes to cultivate compassion among nurses.

Conclusion

The concept of compassion is strongly influenced by the cultural and/or religious characteristics of the environment. In the context of this study, most participants perceived compassion as something negative, with a marked influence of the popular religiosity of the Judaeo-Christian tradition in which compassion is understood as feeling pity or sorrow for someone.

At a deeper level, almost all informants associated compassion with empathy, as if they were similar or even synonymous. They therefore have a narrow view of the attributes that the scientific literature attaches to the concept of compassion. To a lesser extent, informants were found to introduce elements such as presence, shared vulnerability, desire to alleviate suffering, and inner experience of being happy when they do their job compassionately. These levels of conceptualisation of the phenomenon in our context indicate that interventions are needed before compassion can be cultivated. These interventions would facilitate a change in the understanding of compassion by health professionals, in addition to nurturing motivation for training in compassionate care.

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