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TITLE Page

Title **Embodying compassion; a systematic review of the views of nurses and patients.**

Running head **Embodying compassion; nurse and patient views**

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Aim

To provide a review of empirical research investigating how compassion is expressed by nurses and received by patients in hospital settings.

Background

Compassion is viewed as an important and fundamental part of a health professional practice. Universally, reports from both media and government agencies have addressed perceived deficits of compassion in healthcare with nurses accused of a lack of compassion. Research into compassion to date has largely focused on the problematic nature of compassion such as burnout, fatigue and other negative personal and work-related outcomes.

Design

A systematic literature review of empirical research guided by a meta-ethnographic approach supported the systematic comparison and translation of the included studies. Six online databases were searched from January 2006 to December 2016.

Methods

This review was carried out according to the PRISMA- P reporting guidelines. How compassion in healthcare was defined was extracted alongside findings on how compassion was expressed by nurses and received by patients. Synthesis of the research was completed resulting in new interpretations.

Results

Eleven papers met the inclusion criteria and were included in the review. Multiple differing definitions of compassion in healthcare were applied. Nurses embody and enact compassion through behaviours such as spending time with patients and communicating effectively with patients. Patients experience compassion through a sense of togetherness with nurses.

Conclusion

Existing research demonstrated dissonance between the expression of compassion by nurses and how compassion is experienced by patients. The themes identified in this review should be considered by health professionals providing patient care.

Relevance to clinical practice

Health providers should acknowledge and account for the time that nurses need with patients to demonstrate compassion in practice. Nursing education relating to the expression of compassion should articulate both the subjectivity and ambiguity of the term and examine the relationship between compassion and suffering.

Keywords

Literature, review, nurses, nursing, patients, empathy, nurse-patient relations, compassion

'What does this paper contribute to the wider global clinical community?'

- This paper demonstrates that multiple definitions of compassion are being applied within contemporary healthcare research and highlights issues of ambiguity for researchers in the field.
- We provide a more nuanced understanding of how compassion is expressed by nurses and received by patients in a hospital setting; however, ambiguity remains in how compassion is expressed by nurses and received by patients.
- The issues of ambiguity demonstrate the need for further research on the receipt of compassion by patients and expression of compassion by nurses.

INTRODUCTION

The concept of compassion has been used widely in the health literature. The importance of compassion has been highlighted recently in a number of documents that argue the need for nurses to provide compassionate care (Department of Health, 2012; Royal College of Nursing, 2010). Despite these calls, understanding of how compassion is expressed by nurses towards patients and received or experienced by patients in a hospital setting remains unclear as too does the definition of compassion. We see that compassion is demanded of health practitioners without adequate agreement on the meaning of suffering or clarity on the concept of compassion (Hordern, 2013). Despite this lack of consistency, there has been increasing interest regarding a perceived lack of compassion within health systems, the development of compassion fatigue by nurses and ongoing concerns regarding the absence of compassion in the face of patient suffering (Francis, 2013; Health Service Ombudsman, 2011)

Consequently, understanding nurses, and patient's attitudes towards the expression of receipt of compassion is a crucial area of research as the concept of compassion continues to embed into the language of global healthcare.

Background

Compassion is an important component of healthcare (Dewar & Mackay, 2010; Dewar & Nolan, 2013; Straughair, 2012a, 2012b; Strauss et al., 2016) and is considered as an essential component of healthcare professionals' practice (Curtis, 2014). Compassion brings health professionals closer to their patients and enables them to understand and treat the whole person, not just the illness (Kanov et al., 2004; Youngson, 2012, 2014).

Compassionate healthcare results in increased patient satisfaction, higher levels of staff satisfaction and better health outcomes for patients (Youngson, 2012, 2014). For nursing, compassion is part of the essential identity of the profession (McCaffrey & McConnell, 2015) with the development and training of the nurse as a kind and 'compassionate character' historically as important as the

development of the nurses technical competence (Bradshaw, 2009). Compassion forms one of the five nursing professional values (International Council of Nurses, 2012), and is considered a fundamental part of the very ethos of nursing (Bradshaw, 2009; von Dietze & Orb, 2000).

What is compassion?

Compassion involves a person first becoming aware of or noticing another person's suffering (Kanov et al., 2004). The observer may witness the difficulty another is experiencing (Forsyth, 1980) or notice another person's emotional state which conveys to the observer that another person is suffering (Gelhaus, 2012; Liben, 2011; Rorty, 1980; Schantz, 2007). Compassion involves awareness and identification *with* the observed suffering (von Dietze & Orb, 2000), an awareness of another's feelings, and an appreciation of how they are affected by their experience (Dewar, Pullin, & Tocheris, 2011). Compassion is felt by the observer of suffering in a complex set of emotions ranging from concern, empathy and anger at the situation the sufferer finds themselves in (Kanov et al., 2004). The observer of suffering uses their imagination to reconstruct the experiences of the sufferer in order to understand and feel the experience alongside the sufferer (Nussbaum, 2003). These feelings motivate the observer to act and help the sufferer (Goetz, Keltner, & Simon-Thomas, 2010; Lazarus, 1991). Awareness of suffering is followed by action and which takes affective, cognitive, moral and behavioural forms (Carr, 1999; Nussbaum, 2003). The action taken is appropriate for the situation (Schantz, 2007; von Dietze & Orb, 2000) and can be demonstrated through presence, behaviour, and word (Gelhaus, 2012; Liben, 2011; Rorty, 1980; Schantz, 2007). The action involves a deliberate participation in another person's suffering (von Dietze & Orb, 2000) with the objective of the observer alleviating the suffering (Kanov et al., 2004).

Compassion has been described as a controversial concept (Goetz et al., 2010) that is complex, sensitive (Dewar et al., 2011), difficult to explain and define (Kneafsey, Brown, Sein, Chamley, & Parsons, 2016) with attempts to understand and analyse compassion present within philosophical, sociological and evolutionary theories. Drawing on theological, philosophical and political perspectives of the concept, Hordern (2017) describes compassion in terms of the demonstration of *intelligent* compassion which participates in suffering and 'deploys *up-to date clinical evidence, seeks justice, rejoices in mercy and shows critical sensitivity to locality and culture*' (p.32). This description builds on the positioning of compassion as not simply an appropriate response, but a virtuous and emotionally intelligent response to suffering.

Compassion in healthcare is considered a fundamental (Lazarus, 1991) and valued phenomena (Straughair, 2012a, 2012b; van der Cingel, 2009). Understanding compassion is significant within the current healthcare context (McCaffrey & McConnell, 2015) and has been mentioned in a variety of reports that have addressed perceived compassion deficits in healthcare (Care Quality Commission, 2012; Darzi, 2008; Firth-Cozens & Cornwell, 2009; Francis, 2010, 2013). Such reports discussed the absence of compassion as a reason for poor patient outcomes and hospital failings (Crawford, Brown, Kvangarsnes, & Gilbert, 2014). In response to perceived deficits of compassion in nurses there were renewed calls for nurses to return to an apprenticeship form of nursing education (Rolfe, 2014) and to be trained in compassion (Hordern, 2013). This call came despite evidence that perceived deficits in care are not linked to nursing education and where university education for nurses has shown a direct correlation with lower mortality rates in hospital (Aiken et al., 2014; Audet, Bourgault, & Rochefort, 2018)

Perceived deficits in healthcare professional behaviours have generated attempts to measure compassion in healthcare, a move which has been criticized as artificial (Bradshaw, 2009) and potentially unreliable (Sturgeon, 2008). There is an absence of a reliable, validated, internationally relevant measurement tool for compassion (Durkin, Gurbutt, & Carson, 2018) and the complex and largely unseen nature of compassion can lead to a tendency to measure only what is easy to

measure, rather than what is important (Bradshaw, 2009). Empirical research specifically relating the expression and receipt of compassion in healthcare are relatively rare, given its importance. Studies instead tend to focus on the problematic nature of compassion. These include studies of related factors such as burnout, fatigue and other negative personal and work-related outcomes (Hunsaker, Chen, Maughan, & Heaston, 2015) or the presence of perceived barriers to the delivery of compassionate care such as work pressures (Christiansen, O'Brien, Kirton, Zubairu, & Bray, 2015; van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015)

Despite compassion being viewed as important in healthcare (Dewar & Mackay, 2010; Dewar & Nolan, 2013; Straughair, 2012a, 2012b; Strauss et al., 2016) and considered as an essential component of healthcare professionals practice (Curtis, 2014) it remains a poorly understood and articulated concept (Durkin et al., 2018; Sinclair, McClement, et al., 2016).

THE REVIEW

Aim

To provide a review of empirical research investigating how compassion is expressed by nurses and received by patients in hospital settings.

Design

The design used a similar method to Noblit and Hare's (1988) meta-ethnographic approach to support the systematic comparison and translation of the studies. The intellectual interest focused upon was the development of a deeper understanding of how compassion was being expressed by health personnel and how compassion was received by patients in a hospital setting. The authors (JD and KU) jointly screened studies against the inclusion and exclusion criteria. The texts were read and re-read by the first author. Translations of the studies included first extracting findings from each study which related to the following:

- how compassion was expressed by nurses
- how compassion was received by patients
- Study characteristics, specifically country, research design, participant profile and numbers and study setting.

All information was downloaded into an excel spreadsheet for review and discussion by the authors with the initial themes 'expressed' and 'received'. During the initial readings of the text, the authors discussed the absence of a consistently applied definition of compassion within the included literature. The intellectual interest focused upon was expanded to include:

- the definition of compassion used by authors in their study

This additional information was also downloaded into an excel spreadsheet for consideration and discussion between the authors. This review is reported following the Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) (Moher et al., 2015). The PRISMA-P was used to both plan and document the review process while allowing for transparency in the reporting process (Shamseer et al., 2015).

Search methods

The search strategy was designed in consultation with the first author and the university research librarian. The search strategy was then verified by a health librarian at a separate academic institution. Peer-reviewed literature was searched using these databases; CINAHL Complete, Health

& Medical Complete, PubMed Central, Clinic Key (Australia), Sage Journals, Psych Info and Ulrich Web. The following inclusion and exclusion criteria were applied:

Inclusion Criteria

- The setting was a hospital or health care facility
- The research focus was the expression of compassion by nurses towards patients or
- The research focus was the receipt of compassion by patients
- Papers were written in English with full text available in peer reviewed journals
- Papers were published between 2006 and 2016

Exclusion Criteria

- Studies related to ‘others’ perception of the expression or receipt of compassion. Others included family members or other caregivers.
- Studies relating exclusively to the expression of empathy, pity or sympathy in a healthcare setting

Keywords used for the search across all databases included *Patients, Empathy, Compassion, Compassionate Care, Humanising, Physician-patient relations; nurse-patient relations and hospital-patient relations* (See Table 1). Keyword development occurred in consultation with the first author, the higher degree research librarian and health librarian. Initial discussions considered all possible keywords before agreeing on a diverse set of related themes which would capture all relevant literature.

Table 1: Search Strategy Terms

Search Strategy
Patient* or client* or “service user”
Staff* or healthcare personnel or manpower or physician* or doctor* or nurse* or orderlies or orderl*
Physician-patient relation* or Nurse-Patient relation* or Hospital-patient relation* or Professional-patient relation*
Compassion or “Compassionate Care” or empathy or empathising or humanizing
Hospital* or clinic* or NHS or hospice* or health or “health services” or infirmar*

Search outcome

Searches initially yielded 2000+ results not relevant to the field of investigation. Results included editorials, discussion papers and research relating to compassion fatigue. The search strategies applied yielded smaller, more focused and relevant studies for screening and subsequent inclusion. A total of 108 papers were retrieved across CINAHL Complete, Health & Medical Complete, PubMed Central, Clinic Key (Australia), Sage Journals and Psych Info. A further check of Google Scholar resulted in an additional 100 papers being screened for review. References were hand checked across papers resulting in an additional 7 papers being selected for review. A total of 215 papers were identified and screened. Following the initial search, duplicates were removed. Titles and abstracts were then screened to determine relevance and then screened against the eligibility criteria for inclusion (see Figure 1). Data extraction was undertaken from included studies and the variables were entered into Table of Included Studies with Characteristics (Table 2).

Figure 1: PRISMA flow diagram

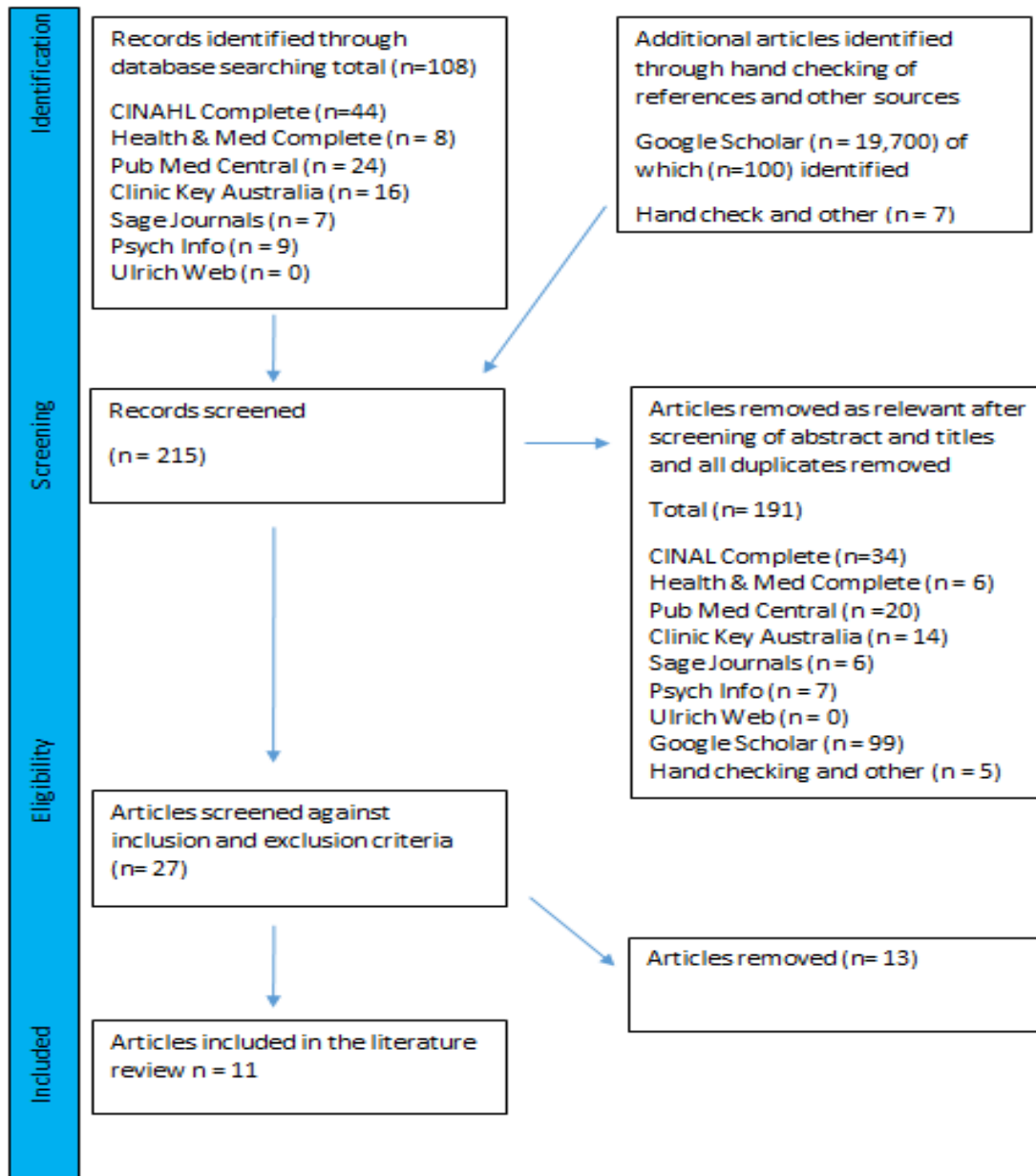


Table 2: Table of Included Studies with Characteristics

Author, year and country	Research design	Sample	Setting	Aims
(Kret, 2011) USA	Descriptive study. Statistical analysis and qualitative interviewing.	Patients (n = 100), nurses (n = 100)	Medical/Surgical	To explore the qualities of compassionate nurses as perceived by patients in medical/surgical wards.
(Sinclair, McClement, et al., 2016) CANADA	Grounded theory; semi-structured interviews	(n=53) patients	Cancer	To investigate palliative care cancer patients understanding and experiences of compassion to provide a critical perspective on the nature and importance of compassion.
(Sinclair et al., 2017) CANADA	Grounded theory; semi-structured interviews	(n=53) patients	Cancer	To investigate patients' perspectives, understandings, experiences and preferences of 'sympathy' 'empathy' and 'compassion' in order to develop conceptual clarity for future research and to inform clinical practice.
(Bramley & Matiti, 2014) UK	Descriptive study. Qualitative exploratory study.	(n=10) patients	Acute medical ward	To understand how patients experience compassion in nursing care and explore patient perceptions of compassionate nurses
(van der Cingel, 2011) NETHERLANDS	Grounded Theory. Qualitative research. Mixed methods.	Patients (n=31) Nurses (n=30)	Rheumatic diseases and chronic obstructive pulmonary disease (COPD).	To understand the benefit of compassion for nursing practice within the context of long-term care.
(Way & Tracy, 2012) USA	Qualitative field study. Mixed method qualitative research.	(n=96) participants	Hospice and Palliative Care	The Aims of this research are not clear; the study explores the communication of compassion at work and provides a new conceptualization of compassion.
(Dewar & Nolan, 2013) UK	Appreciative action research.	Healthcare staff (n=35) patients (n=10)	Acute care; gerontology	To actively involve older people, staff and relatives in agreeing upon a definition of

		families (n=12)		compassionate relationship-centred care and identifying strategies to promote such care in an acute hospital setting for older people.
(Perry, 2009) CANADA	Descriptive phenomenology. Unstructured interviews.	Nurses (n=7). Unstructured interviews. Observation (n=?)	Long term elderly care.	To discover some of the means by which nurses let older people know that they sense their suffering and are willing to try to relieve or at least reduce it.
(Horsburgh & Ross, 2013) UK	Grounded theory. Qualitative. Focus groups	(n=42) student nurses in focus groups.	Various including: acute care, chronic/enduring conditions, community care.	To explore newly qualified staff nurses perceptions of compassionate care and factors that facilitate and inhibit its delivery.
(Fry et al., 2013) AUSTRALIA	Qualitative exploratory study	(n=16) non-participant observations undertaken.	Emergency department.	To explore what emergency nurses do in their extended practice role in observable everyday life in the emergency department. Focus of research was the clinical initiative nurse (CIN).
(Curtis, Horton, & Smith, 2012) UK	Grounded theory informed by Symbolic interactionism	(n=19) student nurses	Various	The aim of the study was to explore the student nurse experience of socialisation in the 21st century compassionate practice, the concerns students had in relation to the provision of compassionate practice and how they managed these concerns.

Quality appraisal

The 11 papers included in the final review were examined using the Critical Appraisal Skill Programme (CASP, 2014) (See Table 3). The CASP appraisal identified 9 of the 11 papers met the criteria for inclusion. Two articles were included despite not meeting the CASP criteria, namely due to methodological concerns with the quantitative tool used failing to adequately define the characteristics of compassion; a limitation acknowledged by the author (Kret, 2011). Respondents in that study were asked to rank participants as 'Compassionate or Distant' which makes it difficult to assess the face validity of the results. Further methodological concerns related to *clear* aims and objectives outlined within the presentation of the study (Way & Tracy, 2012). Despite these

omissions, the findings of the research were deemed a valuable contribution to the field and for the purpose of this analysis and thus are included. The first and second author separately appraised the studies using the CASP appraisal and came to a consensus about the quality and rigor of each study.

Table 3: CASP Appraisal

Author	Clear aim & objective	Appropriate methodology	Appropriate research design	Appropriate recruitment strategy	Data collection justified	Author and participant relationship	Ethical consideration	Rigor	Findings	Value of Research
(Kret, 2011)	Y	N								
(Sinclair et al., 2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Sinclair et al., 2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Bramley & Matiti, 2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(van der Cingel, 2011)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Way & Tracy, 2012)	N									
(Dewar & Nolan, 2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Perry, 2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Horsburgh & Ross, 2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Fry et al., 2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Curtis, Horton, & Smith, 2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Data abstraction and Synthesis

The findings were identified from the repeated reading of texts with text extracted from each paper by the first author. Information relating to how compassion in healthcare was defined within each paper was extracted. Then the results/findings on the expression and receipt of compassion in healthcare were explored in collaboration with the second author. Translation of the studies involved open coding of findings within an excel spreadsheet before codes were grouped into themes. The open coding involved line by line coding of the findings sections to search for concepts. The open coding involved line by line coding of the findings sections whereby statements were extracted from each of the paper's if they related to the field under investigation (n=363). Findings were first grouped based on word similarity, concepts and patterns within the data which related to expression or receipt of compassion. Data were synthesised into unifying sub themes. Analysis of these open

codes resulted in (n-31) sub themes which were then re-examined by the first and second author to check for any consistencies or incongruities. The sub-themes were then synthesised to form five representative themes. These representative themes are presented in this paper as; *virtuous motivation, emotional connection, communication and building understanding, being present and taking action to provide individualised care*.

Results

The definition of compassion used by authors in their study

The results of the review found that defining compassion within the research could be understood in terms of the following defining qualities; awareness of/noticing/sensing suffering in another; participation in the suffering; empathising or suffering with another; being moved to alleviate the suffering of another; and taking appropriate action to relieve the suffering of another through appropriate response. Nearly all definitions used are linked to suffering, except Dewar and Nolan (2013) who acknowledge awareness of another's feelings as a defining quality of compassion. The multiple definitions applied throughout the research, reflects the differences in researchers understanding of what compassion comprises of within healthcare (see Table 4).

Table 4: Definitions of Compassion used in included papers

Author	Definition of compassion
Perry, 2009	Sensing another's suffering and having a desire to alleviate a person's suffering * (Shultz, et. al., 2007) *Shultz was informed by American Heritage dictionary 2000 and Oxford English Dictionary 1989
Kret, 2011	Denoting sorrow or pity upon witnessing the plight of another (Forsyth, 1980) Sharing the burden with the sufferer (Von Dietz & Orb, 2000) An outcome of empathy (Benbassat & Baumal, 2004)
Van der Cingel, 2011	The <i>process</i> of compassion is primarily triggered by the suffering of another. The process of action is affective, cognitive, behavioral and moral (Carr, 1999; Nussbaum, 2003)
Way & Tracy, 2012	Noticing another's emotional state. Empathizing with the persons pain/ suffering . Taking action to alleviate the suffering of another (Kanov et. al., 2004). Connecting with, rather than feeling for individuals (Miller, 2007)
Curtis et. al., 2012	Sympathetic pity or concern for the misfortune of others (Oxford dictionary of English, 2009) Identification of and with the suffering of another, and taking action to alleviate that suffering (Von Dietz & Orb, 2000)
Dewar & Nolan, 2013	Compassion primarily involves an awareness of another's feelings, an appreciation of how they are affected by their experiences and interacting with them in a meaningful way. (Dewar et. al., 2011)
Hosburgh & Ross, 2013	Sympathetic pity or concern for the misfortune of others (Oxford dictionary of English, 2009) Recognition of suffering (Nussbaum, 2003). Having an appropriate response to the suffering and sharing the burden with the sufferer (Von Dietz & Orb, 2000 and Shantz, 2007)
Fry et. al., 2013	Identification of and with the suffering of another and deliberate participation in another person's suffering (Von Dietz & Orb, 2000)
Bramley & Matiti 2014	Deep awareness of suffering and a desire to relieve suffering . Having a meaningful response to the suffering and acting in a meaningful way (Dewar et.al., 2011) Having ethical dimensions'...steeped in the Aristotelian virtue of suffering ...' p 2971 (Von Dietz & Orb, 2000)

Sinclair et.al., 2016	Deep awareness of suffering coupled with a desire to relieve suffering (American Heritage dictionary of English Language, 2011)
Sinclair et.al., 2017	Suffering with another (Concise English dictionary, Hoad, 1996) A virtuous response which seeks to address the suffering through relational understanding and action (Sinclair et. al., 2016)

Thematic analysis of extant contemporary literature

The themes identified in the literature were virtuous motivation, emotional connection, communication and building understanding, being present and taking action to provide individualized care and are presented in Table 5.

Table 5: Themes identified within included literature

	(Kret, 2011)	(Sinclair, McClement, et al., 2016)	(Sinclair et al., 2017)	(van der Cingel, 2011)	(Bramley & Matti, 2014)	(Horsburgh & Ross, 2013)	(Curtis, Horton, & Smith, 2012)	(Dewar & Nolan, 2013)	(Fry et al., 2013)	(Perry, 2009)	(Way & Tracy, 2012)
Virtuous Motivation	X	X	X	X		X				X	
Emotional connection		X		X	X	X	X	X	X		X
Communication and building an understanding	X	X	X	X	X	X	X	X	X	X	X
Being present		X		X			X	X		X	X
Taking action and providing individualised care	X	X	X	X	X	X		X	X	X	X

Virtuous motivation

The patient is aware of and is engaged by the virtues of the nurses caring for them specifically beneficence, love and kindness (Kret, 2011; Sinclair, McClement, et al., 2016; Sinclair et. al., 2017). Motivation for the expression of compassion stemmed from a desire to act when a patient was observed to be suffering (Perry, 2009), to take care of the patient because they were in need (van

der Cingel, 2011) and by the nurse doing the best they can to care (Horsburgh & Ross, 2013). Patients and nurses agreed that a trigger or motivation for compassion was suffering (van der Cingel, 2011). Nurses associated compassion with a wish to do something good for someone else (Sinclair et al., 2017) with expression of compassion stemming from beneficence and a genuine love and kindness (Kret, 2011; Sinclair et al., 2017; Sinclair, McClement, et al., 2016). Love related to the love for a patient and a love for their profession (Sinclair et al., 2017) and it is this concept of love which distinguished compassion from sympathy (Sinclair, McClement, et al., 2016). Feeling sorry for the patient was seen to evoke a powerlessness which infects the nurse and victimized the patient (van der Cingel, 2011).

Emotional connection

Nurses describe their ability to recognise and connect with the emotions they observe in their patients (van der Cingel, 2011) and rather than simply acknowledging and understanding these emotions, they actively engage in the suffering of the patient (Sinclair, McClement, et al., 2016). This active engagement creates a heartfelt connection between the patient and nurse (Way & Tracy, 2012). Entering into the patient experience was understood by the nurse as putting yourself in the patients shoes to understand how it felt to be in the patients' position (Curtis, 2014; Sinclair, McClement, et al., 2016) and this required imagination on the part of the nurse (van der Cingel, 2011). Connection involves entering into the patient experience (Bramley & Matiti, 2014) a desire to understand a person's suffering (Sinclair, McClement, et al., 2016).

Connection was created when patient is seen as an individual, not an illness (Sinclair, McClement, et al., 2016) and is treated with respect, dignity (Curtis, 2014; Horsburgh & Ross, 2013), and genuine concern (Sinclair, McClement, et al., 2016). These interpersonal connections between patients, nurses and colleagues are core nursing skills (Fry et al., 2013) requiring attentiveness (Kret, 2011) truly knowing the patient and understanding their needs (Sinclair, McClement, et al., 2016). Connections are created by asking the patient how they feel and establishing a shared understanding of these feeling (Dewar & Nolan, 2013). The nurse becomes concerned about the patient in the same way the patient is concerned about themselves and a connection is created (van der Cingel, 2009). A key component of connection between patient and nurse is time needed to build this connection (Bramley & Matiti, 2014). The absence or lack of a connection between patient and nurse on an interpersonal level is linked to stress for both nurse and patient (van der Cingel, 2011).

Communication and building understanding

Communication is used by the nurse to understand the patient perspective (Dewar & Nolan, 2013; Way & Tracy, 2012) to find out what is happening with them (Curtis, 2014; van der Cingel, 2011) and build therapeutic relationships (Fry et al., 2013). Communication requires warmth (Dewar & Nolan, 2013; Horsburgh & Ross, 2013), professionalism (Kret, 2011) and curiosity on the part of the nurse to gather as much information as needed to help the patient (Dewar & Nolan, 2013). Communication between the nurse and the patient involves the nurse making time to understand the source of the patients' distress, actively searching for their needs (Perry, 2009; Way & Tracy, 2012), providing encouragement (Bramley & Matiti, 2014) and keeping the patient informed through their treatment (Kret, 2011).

Verbal and non-verbal communication affect the behaviour and engagement with the patient who is suffering (Sinclair, McClement, et al., 2016). This engagement helps to the patient to communicate their motivations and goals for treatment (van der Cingel, 2011) enabling the nurse and the patient to work in partnership (Dewar & Nolan, 2013). Communication between nurse and patient allows for the verbalisation of suffering by the patient and the acknowledgement from the nurse that their story

has been heard and understood (van der Cingel, 2011) which allows for the expression and receipt of compassion.

Compassionate communication involves assessment of needs, advising, teaching and facilitation of the needs of the patient (Way & Tracy, 2012) with knowledge from previous experiences used to interpret significance of information being heard (van der Cingel, 2011). Advancing their understanding of the communication that occurred between patient and nurse, Dewar and Nolan (2013) developed the 7Cs of caring conversations which are; *Courageous, Curious, Collaborative, Considering, Compromising and Celebratory*. Caring conversations enable nurse and patient to work as partners to shape the care provided (Dewar & Nolan, 2013). While there is a connection between caring and compassion, they remain separate, multifaceted concepts. Caring conversations are used to communicate compassion. This communicative interplay appears to the nurse and the patient as spontaneous with nurses unaware they were using complex communication techniques with patient (Way & Tracy, 2012).

Being present

There is an active presence required in encounters between patient and nurse for compassion to be expressed and received (Sinclair, McClement, et al., 2016). This concept relates to physical presence, emotional presence and presence of mind (van der Cingel, 2011). Presence is understood in terms of 'being there' for patients and providing companionship in times of distress (Perry, 2009). Being present is a conscious choice made by the nurse who notices and is aware of the need of his or her presence (van der Cingel, 2011). Presence allows the nurse to pay attention and make sense of the verbal and non-verbal messages being received from patients (Perry, 2009; Way & Tracy, 2012) and notice what these messages mean to the patient (Dewar & Nolan, 2013; van der Cingel, 2011).

Presence was considered a point of contention with student nurses who felt once they qualified, time with patients would be limited and thus limited opportunities existed to express compassion (Curtis, 2014) but while time should be made to be present with patients, the time needed to convey compassion is fleeting (Bramley & Matiti, 2014). The nurse is present at the end of the patients journey and promises not to abandon the patient when it appears that other health professionals have given up (Perry, 2009).

Taking action to provide individualised care

A quintessential feature of compassion is action (Sinclair, McClement, et al., 2016). Compassionate actions were implied through such descriptors as supererogatory acts (Sinclair et al., 2017) re-acting to needs (Way & Tracy, 2012) and small important actions (Perry, 2009). The action taken conveys compassion and creates a unique, personalized experience for the patient (Bramley & Matiti, 2014) the objective of which is the amelioration of suffering (Sinclair et al., 2017). Action is tailored to meet the needs of the patient (Sinclair, McClement, et al., 2016) showing a level of attentiveness required to provide a personalized individual service for the patient (van der Cingel, 2011).

Van der Cingel (2011) discusses compassionate acts in terms of 'helping'. This can be helping with simple tasks, to helping with more complex interactions, such as mediation between patient and doctor. But at the heart of helping is that these compassionate acts always concern what is of real importance to the patient (van der Cingel, 2011). Taking action can also take the form of inaction; such as leaving the patients time to be alone with quiet time and space (Way & Tracy, 2012) and acknowledging that the patient may need silence while they are distressed (Horsburgh & Ross, 2013).

The action taken actively and tangibly aims address the needs of the person who was suffering (Sinclair, McClement, et al., 2016) and even everyday acts are often imbued with subtle meaning and significance (Dewar & Nolan, 2013). It was through supporting patients with every day ordinary activities such as sitting, bathing and feeding that nurses found opportunities to convey compassion (Perry, 2009). Simple acts such as making a patient feel comfortable (Horsburgh & Ross, 2013) or asking the patient if they would like to hold the nurses hand in times of suffering (Fry et al., 2013) Compassionate action was often non-remunerated or part of the job description (Sinclair et al., 2017) but essential components in providing compassion.

DISCUSSION

Throughout this review, the authors discussed the absence of a consistently applied definition of compassion within the included literature. The synthesis of the applied definitions presented a fuller picture of how compassion could be understood within healthcare research in terms of the constructs defining qualities. Also apparent within the included definitions was an understanding that compassion cannot occur without suffering. This is not surprising considering the Latin and French routes of the word itself stemming from *compati* 'to suffer with' (Gilbert, 2015; Von Dietze & Orb, 2000). But etymology alone cannot fully encapsulate the contemporary uses of the construct and overreliance may lead to continued ambiguity (Walker & Lovat, 2017). To test and discuss theory researchers must clearly and unambiguously define the conceptual construct (MacKenzie, 2003) and across the body of compassion literature, there is an acknowledgement that the definition of the term is challenging. Despite these challenges, the connection with suffering or the sufferer was ever present (Goetz et al., 2010; Greenberg & Turksma, 2015; van der Cingel, 2009). Individual definitions applied within the included studies left the authors recognising that compassion remained a subjective and ambiguous concept and ongoing research on the topic was an important part of reducing said ambiguity.

In drawing together, the literature included in this review we provide clarity on this complex and important topic. We see connection to the virtuous motivation nurses have in expressing compassion playing a part in the receipt of compassion by patients. Patients described being aware of and engaged by the virtues of the nurses who cared for them. These virtues were understood in terms of love, kindness and beneficence. McGaghie, Mykto, Brown and Cameron (2002) describe compassion as the foundation altruism, and the expression of altruistic acts are grounded in an individual's 'compassionate core'. More recently, Zamanzadeh et. al., (2018) found that altruistic motives played a helpful role in participants demonstrating compassion towards their patients.

This literature review allowed the authors to see that compassion in healthcare was motivated by the virtues of the nurse which were observed and understood by the patient. The expression and receipt of compassion required an emotional connection between the patient and the nurse and complex communication skills were used to build understanding, strengthening the connection. To express compassion, the nurse needed to be physically and emotionally present in the interactions before taking action with the ultimate goal of reducing the observed suffering.

The response to suffering involved recognition that a person was suffering, followed by the need to take action. With awareness and recognition, action followed. This reinforces the understanding of compassion in healthcare as participative in nature (Hordern, 2017) with the orientation towards action in response to suffering that differentiated compassion from other constructs such as empathy or sympathy (Sinclair, Norris, et al., 2016). The form the response to suffering took was varied and not always explicit. There were references to the relationships between the nurse and the patient, compassionate communication and actions that were considered compassionate. This supports the authors understanding of compassion as a relationship between 'the sufferer' and 'the observer of suffering'.

Compassion is something that appears as done together with nurse and patient not something carried out in isolation (Dewar & Nolan, 2013) the prefix 'com' is rooted in the Latin for 'together with' (van der Cingel, 2009). Seeing compassion as something that is done, albeit together, may limit researchers understanding of the concept (Dewar & Nolan, 2013). Despite the complexities identified there are ways nurses embody and enact compassion. In terms of understanding the expression and receipt of compassion, we find that the terms expressed are strongly linked to compassion as a response to suffering. Suffering itself is a complex phenomenon which may be physical, existential, spiritual or holistic suffering (Fridh et al., 2015; Rodgers & Cowles, 1997). When reviewing the way in which nurses' express compassion, through attending to needs, paying attention and helping, it could be implied that these are in response to suffering, but they are not always explicit in the descriptions given within the extant literature. Being professional does not on its own mean being compassionate but having a professional response to *suffering* can be reflected an expression of compassion (Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006).

Perhaps the most explicit act which nurses felt they expressed compassion are 'supererogatory' which by definition are behaviours which are morally good and superfluous to need (Sinclair et al., 2017). John Paley (2014) wrote that perceived deficits of care identified in the Francis Reports (2010, 2013) failed to distinguish between compassionate behaviours which he termed 'helping behaviours' and compassionate motives of the staff within the hospital. This, he said, called into question the assumption that a deficit in helping behaviours indicated a lack of compassion.

Patients describe receiving compassion when they felt known by nurses and when nurses spend time with them (Dewar & Nolan, 2013). This concept of time is implicitly present across other components of the receipt of compassion such as the time to be present (van der Cingel, 2011) and time to keep the patient informed (Kret, 2011). It is present when having appreciative caring conversations (Dewar & Nolan, 2013). It is present when nurses spend time with the patient despite the appearance that they do not have the time to give (Bramley & Matiti, 2014). Compassion is a partnership in suffering between the nurse and the patient. Compassion is essential for the individual and communal wellbeing (McGaghie et al., 2002). Being present is an essential component and precursor to expression and receipt of compassion. Consistent across all of the components of compassion described by patients is the concept of togetherness. The challenges for conveying compassionate acts, identified by students and newly qualified nurses, were largely associated with the absence of time to be compassionate (Curtis, Horton, & Smith, 2012; Horsburgh & Ross, 2013). Rather than consider time as something needed to convey helping behaviours, it appears that time is needed for the nurse, as the observer of suffering, to emotionally connect and engage with the patient as sufferer.

Limitations

This review was limited in that it was restricted to papers published in English and from a small body of evidence to rely on. The search strategy applied an exclusion criterion to reveal literature concerned with the expression and receipt of compassion in a hospital setting. This could conceivably be broader in future reviews to include research conducted within primary and secondary care. It is evident from this paper that the topic of compassion in healthcare is important across a wide range of health settings. Additionally, all research included in this review included patients who were conscious and responsive to the communication and behaviour of nurses. It does not account for the expression of compassion towards patients with impaired states of consciousness. Furthermore, caveats must be voiced about the generalizability of the findings, as the studies were all conducted in developed countries. Similar studies in developing countries might yield very different results and implications for practice.

CONCLUSIONS

Compassion is a valued component in nursing as recognized in the international ethical standards of nursing practice (International Council of Nurses, 2012). Within this review we provided a more nuanced understanding of how compassion is expressed by nurses and received by patients in a hospital setting. Despite the well-recognized importance of compassion in healthcare, the findings of this review indicate that ambiguity remains in how compassion is expressed by nurses and received by patients. This ambiguity is fostered with differing definitions of compassion being applied within health care research. This review strengthened the connection between compassion as a response to suffering. Compassion occurs in partnership with nurse as the observer of suffering and patient as the one who suffers. The expression of compassion by nurses relies largely, within the included research, on the recognition and emotional resonance with suffering. Further, nurses express an emotional connection with the patient and use complex communication to build and understanding of the patient's needs which in turn is an expression of compassion. The physical and emotional presence of the nurse precedes the expression and receipt of compassion. Patients understanding of compassion correspond to the concept of togetherness with the nurse. This feeling of togetherness is fostered when a nurse is approachable, keeps them informed and spends time understanding what they need when they are suffering. Further research on the receipt of compassion by patients is advised to advance the understanding of the expression and receipt of compassion.

RELEVANCE TO CLINICAL PRACTICE

This review has further outlined the ambiguity surrounding the concept of compassion in healthcare for health providers, health professionals and patients. Further, the link between compassion and the patient's suffering is strengthened to encompass both recognition of suffering and a need to act in response to the suffering. Patients understanding of compassion correspond to the concept of togetherness with the nurse. Feelings of togetherness is fostered when a nurse is approachable, keeps the patient informed and spends time understanding what they need when they are suffering. Health providers should acknowledge and account for the time that nurses need with patients to demonstrate compassion in practice. Nursing education relating to the expression of compassion should articulate both the subjectivity and ambiguity of the term and examine the relationship between compassion and suffering.

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