

# BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (<http://bmjopen.bmj.com>).

If you have any questions on BMJ Open's open peer review process please email [info.bmjopen@bmj.com](mailto:info.bmjopen@bmj.com)

# BMJ Open

## The Healthcare Provider Compassion Model: A Grounded Theory Study

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2017-019701
Article Type:	Research
Date Submitted by the Author:	21-Sep-2017
Complete List of Authors:	Sinclair, Shane; University of Calgary, Faculty of Nursing Hack, Thomas; University of Manitoba, Rady Faculty of Health Sciences Raffin, Shelley; University of Calgary, Nursing McClement, Susan; University of Manitoba, Rady Faculty of Health Sciences Stajduhar, Kelli ; University of Victoria, Faculty of Nursing Singh, Pavneet; University of Calgary, Faculty of Nursing Hagen, Neil; University of Calgary, Oncology, Cumming School of Medicine Sinnarajah, Aynharan; University of Calgary, Palliative Care Chochinov, Harvey Max; University of Manitoba,
Keywords:	compassion, compassionate care, grounded theory, healthcare providers, model, QUALITATIVE RESEARCH

SCHOLARONE™  
Manuscripts

## The Healthcare Provider Compassion Model: A Grounded Theory Study

Shane Sinclair PhD,<sup>1,2</sup> Thomas F. Hack PhD,<sup>3,4,5</sup> Shelley Raffin-Bouchal PhD,<sup>1</sup> Susan McClement PhD,<sup>3,4</sup> Kelli Stajduhar PhD<sup>6</sup>, Pavneet Singh PhD<sup>1</sup>, Neil Hagen MD, FRCPC,<sup>2,8</sup> Aynharan Sinnarajah MD MPH CCFP (PC),<sup>2,7</sup> Harvey Max Chochinov MD, PhD, FRCPC, FRSC<sup>3,9</sup>

1 Faculty of Nursing, University of Calgary, 2500 University Drive NW Calgary, Alberta Canada. T2N 1N4.

2 Department of Oncology, Cumming School of Medicine, University of Calgary, 2500 University Drive NW, Calgary, Alberta, Canada. T2N 1N4.

3 Research Institute in Oncology Hematology, Cancer Care Manitoba, 4005E – 675 McDermot, Winnipeg, Manitoba, Canada. R3E 0V9.

4 College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, 89 Curry Place, Winnipeg, Manitoba, Canada. R3T 2N2.

5 School of Health Sciences, University of Central Lancashire, Brook Building (4<sup>th</sup> Floor, Room BB440), Preston, United Kingdom PR1 2HE

6 School of Nursing and Institute on Aging and Lifelong Health, University of Victoria, R Hut, Room 103, Victoria, British Columbia, Canada. V8P 5C2.

7 Palliative / End of Life Care, Calgary Zone, Alberta Health Services, 710 South Tower, 1403 – 29<sup>th</sup> Street NW, Calgary, Alberta, Canada. T2N 2T8.

8 Departments of Clinical Neurosciences and Medicine, Cumming School of Medicine, University of Calgary, 2500 University Drive NW, Calgary, Alberta, Canada. T2N 1N4.

9 Department of Psychiatry, University of Manitoba, 771 Bannatyne Avenue, Winnipeg, Manitoba, Canada. R3E 3N4.

Word Count: 3874 (excluding title page, abstract, references, figures, tables and participant quotes). 5600 (including participant quotes).

Keywords: compassion; compassionate care; grounded theory; healthcare providers; model; qualitative

Corresponding author: Dr. Shane Sinclair

Address: Faculty of Nursing, University of Calgary, PF 2280, 2500 University Drive NW  
Calgary, Alberta Canada. T2N 1N4

Tel: 403.220.2925

e-mail: [sinclair@ucalgary.ca](mailto:sinclair@ucalgary.ca)

fax: 403.284.4803

## ABSTRACT

**Background:** Healthcare providers are considered the primary conduit of compassion in healthcare. Although most healthcare providers desire to provide compassion and patients and families expect to receive it, an evidence based understanding of the construct and its associated dimensions from the perspective of healthcare providers is lacking.

**Objectives:** The aim of this study was to investigate healthcare providers' perspectives and experiences of compassion in order to generate an empirically derived, clinically informed, theoretical model.

**Design:** Data was collected via focus groups with frontline healthcare providers and interviews with peer-nominated exemplary compassionate healthcare providers. Data was independently and collectively analyzed by the research team in accordance with Straussian grounded theory.

**Setting and Participants:** 57 healthcare providers were recruited from urban and rural palliative care services spanning hospice, homecare, hospital based consult teams, and a dedicated inpatient unit within Alberta, Canada.

**Results:** Five categories and 13 associated themes were identified, illustrated in the Healthcare Provider Compassion Model depicting the dimensions of compassion and their relationship to one another. Compassion was conceptualized as -- A virtuous and intentional response to know a person, to discern their needs, and ameliorate their suffering through relational understanding and action.

**Conclusions:** An empirical foundation of healthcare providers' perspectives on providing compassionate care was generated. While the dimensions of the Healthcare Provider Compassion

1  
2  
3 Model were congruent with the previously developed Patient Model, further insight into  
4  
5 compassion was provided. The Healthcare Provider Compassion Model provides a model to  
6  
7 guide clinical practice and a foundation to inform research focused on developing interventions,  
8  
9 measures and resources to improve it.  
10  
11  
12

13  
14 Keywords: compassion; compassionate care; grounded theory; healthcare providers; model;  
15  
16 qualitative  
17  
18

19 **Strengths and limitations of this study:**  
20

- 21 • This grounded theory study delineates the key domains of compassion from direct reports  
22 of a large qualitative sample (n=57) consisting of frontline healthcare providers,  
23 nominated exemplary healthcare providers, and key stakeholders across three distinct  
24 data collection phases.  
25  
26
- 27 • A healthcare provider definition and theoretical model of compassion, extends the largely  
28 theoretical nature of the compassion literature to a clinically informed and clinically  
29 relevant model that can serve as a framework for policy, practice, education and research.  
30  
31
- 32 • By recruiting healthcare providers from palliative care, variance in perspectives and  
33 experiences of compassion based on other practice settings, patient populations,  
34 subspecialties and cultures were not captured.  
35  
36
- 37 • By utilizing through purposive, snowball and theoretical sampling techniques, our sample  
38 may have been overly represented by like-minded individuals who had an affinity toward  
39 the topic and their ability to provide compassion.  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## BACKGROUND

Compassion is considered a vital component of quality healthcare. Healthcare providers (HCPs) are increasingly recognized as the primary, front line conduits of compassionate care, and not surprisingly, the first target of criticism when compassion is lacking.<sup>1-8</sup> Despite their instrumental role in delivering compassionate care within the healthcare system, there is a lack of research investigating HCPs understandings and experiences of providing compassionate care directly.<sup>9</sup>

Recently, our research team identified a similar and equally concerning gap—the absence of direct patient accounts of compassion—leading to the development of an empirically derived, patient informed, theoretical model of compassion,<sup>10</sup> generating the following patient informed definition-- “a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action”.<sup>10</sup> Much like the dearth of patient perspectives in the literature, we were able to identify only a few studies investigating HCP perspectives of compassion, most of which utilized predetermined researcher generated definitions rather than establishing conceptual validity from the perspective of individuals actually involved in providing compassion.<sup>11-14</sup> These studies identified a wide array of behaviours, skills, and attitudes associated with compassion including: relating to the patient as an individual;<sup>14-19</sup> re-acting to suffering;<sup>14 20 21</sup> presence;<sup>21</sup> giving time and listening,<sup>16 21-23</sup> understanding patients’ feelings,<sup>21 22 24</sup> confronting,<sup>21</sup> caring,<sup>21</sup> a moral virtue,<sup>22</sup> intelligent kindness,<sup>25</sup> empathy,<sup>11 20 22 24</sup> assisting patients to make their own decisions,<sup>22</sup> acting in patients’ best interests.<sup>22</sup> In the few studies that asked participants to define compassion directly, psychotherapists identified it as “connecting the clients suffering and promoting change through action”.<sup>13</sup> A group of healthcare stakeholders defined compassion as “the combination of

1  
2  
3 underpinning emotions (such as sympathy and empathy), with altruistic values (particularly a  
4 desire to help others), which together motivated an individual to take action that would  
5 ultimately be experienced as ‘care by the recipient’.<sup>26</sup> While these studies provide some initial  
6 insight into conceptualizations of compassion from the perspective of providers, they are limited  
7 in their: representativeness of interdisciplinary perspectives, lack of specificity in identifying the  
8 key domains of compassion, delineation of compassion to related concepts such as care, empathy  
9 and sympathy; and methodological rigor.<sup>9</sup>

10  
11  
12  
13  
14  
15  
16  
17  
18  
19 The consequences of these issues extend beyond the realm of scholarship, having  
20 considerable implications for healthcare education and practice. Increasingly, governments,  
21 patients, and healthcare institutions consider compassion a clinical necessity and not simply an  
22 ‘optional extra’. Compassion has been considered a standard of care,<sup>4,27</sup> an admission  
23 requirement for healthcare education,<sup>27-29</sup> and a practice competency.<sup>2,27</sup> As a result, educators,  
24 HCPs and trainees are encouraged, expected, and increasingly held accountable for their  
25 competency (or lack thereof) in providing compassion, without a rubric defining and delineating  
26 the key attitudes, knowledge, skills and behaviours that are to be taught and learnt.  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38

39 To address these gaps, this grounded theory study investigated the perspectives and  
40 experiences of HCPs on the construct of compassion, in order to develop a conceptual model  
41 illustrating its key dimensions and their relationship to one another.  
42  
43  
44

## 45 **METHODS**

### 46 **Study population**

47  
48  
49  
50 After receiving approval to conduct this study from the University of Calgary Conjoint  
51 Health Research Ethics Board (#REB 15-1999), HCPs were recruited through convenience  
52 sampling, snowball sampling, and theoretical sampling,<sup>30</sup> whereby certain types of participants  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 (gender, ethnicity, profession, etc.) are sampled to ensure a heterogeneous sample and to address  
4 theoretical gaps. HCPs were recruited between October 2015 and September 2016 from the  
5 palliative care services of the Calgary Zone in Alberta, Canada, which is comprised of urban and  
6 rural palliative care services spanning hospice, homecare, hospital based consult teams, and a  
7 dedicated inpatient palliative care unit. HCPs were eligible to participate if they: i) were at least  
8 18 years of age; ii) were able to read and speak English; iii) worked in palliative care for at least  
9 6 months; iv) were able to provide written informed consent. Although sample sizes are not  
10 predetermined in qualitative studies, based on our previous grounded theory research,<sup>10 31 32</sup> we  
11 aimed to recruit approximately 50 HCPs. Ultimately, 57 participants were required to develop  
12 the theoretical model and reach saturation (Table 1).  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



**Table 1: Demographic Information** (Numbers expressed as percentages and (n))

<b>Mean Age (Years)</b>	48.6
Men	14 (8)
Women	86 (49)
<b>Mean number of years in palliative care (range)</b>	11.8
<b>Employment Status*</b>	
Full-time	57.8 (33)
Part-time	33.3 (19)
Casual	7.0 (4)
<b>Profession</b>	
Registered Nurse	45.6 (26)
Physicians	22.8 (13)
Healthcare Aide	7.0 (4)
Spiritual Care Specialist	5.2 (3)
Unit Clerk	3.5 (2)
Occupational Therapist	3.5 (2)
Licensed Practical Nurse	3.5 (2)
Housekeeper	1.7 (1)
Social Worker	1.7 (1)
Psychologist	1.7 (1)
Respiratory Therapist	1.7 (1)
Physiotherapist	1.7 (1)
<b>Care Setting**</b>	
Home Care	29.8 (17)
Hospice	26.3 (15)
Hospital Dedicated Palliative Care Unit	21.0 (12)
Hospital Palliative Care Consult Service	14.0 (8)
Palliative Care Administrator	7.0 (4)
Outpatient Oncology Palliative Care Consult Service	5.2 (3)
Rural Palliative Care Consult Service	5.2 (3)
Other	1.7 (1)
<b>Religious Affiliation*</b>	
Christian	52.6 (30)
Buddhist	7.0 (4)
Jewish	3.5 (2)
Muslim	1.7 (1)
Hindu	1.7 (1)
None	31.5 (18)
<b>Religious and Spiritual Status*</b>	
Spiritual and Religious	33.3 (19)
Spiritual but not Religious	56.1 (32)
None	8.7 (5)

\* The total for these categories is less than 100% due to non-responses by participants

\*\*The total for these categories is more than 100% due to some participants working in multiple care settings

## Data collection

Data were collected via an interview guide (Tables 2-4) using focus groups and one-on-one semi-structured interviews across three study stages. In the first stage, 35 frontline HCPs participated in 7 focus groups in order to obtain an understanding of the perspective of a broad cohort of interdisciplinary care providers. The second stage involved interviews with HCPs who were nominated by their peers as exemplary compassionate care providers. Exemplary compassionate care providers were identified by focus group participants, via a question within the study demographic questionnaire. A total of 15 individual interviews were conducted, with 3 of these individuals also participating in Stage 1 focus groups. The final stage of data collection occurred through two focus groups with study participants (n=5) and key stakeholders (n=10) (administrators, clinical leads and health faculty educators) to assess the validity of the model; to facilitate knowledge translation and future research directions; and to fulfill the criteria for rigor: fit; work; relevance; and modifiability.<sup>33</sup> The focus groups and interviews were audio-recorded and transcribed verbatim, with contextual content (ex. emotions, non-verbal communication) being recorded in the form of field notes.

**Table 2: Stage 1 Focus Group Guiding Questions**

1. Based on your professional and personal experience, what does compassion mean to you?
2. Can you give me an example of when you felt you provided or witnessed care that was compassionate? [What do you feel were the key aspects of these interactions?]
3. What do you feel are the major influencers of compassionate care in your practice?
4. What do you feel inhibits your ability to provide compassionate care?
5. Do you think patients and/or family members influence the provision of compassionate care? [How or how not?], [If yes, what characteristics of patients and/or families, do you feel facilitate or inhibit compassionate care?]

6. What advice would you give other healthcare providers on providing compassionate care?
7. Do you think we can train people to be compassionate? [If so, how]?
8. Based on your experience what role, if any, do you feel compassion has in alleviating end of life distress? [What happens when compassionate care is lacking?]
9. What impact does providing compassionate care have on your personally and professionally?
10. Is there anything related to compassion that we have not talked about today that you think is important or were hoping to talk about?

**Table 3: Stage 2 Interview Guiding Questions**

1. You have been identified by your peers as possessing great skill in providing compassionate care. What do you feel might be some of the reasons for this recognition? [Why do you think others identify you as a compassionate healthcare provider]?
2. In your own terms, how would you define compassion? [What does compassion mean to you?]
3. How did you become a compassionate caregiver? [What beliefs, situations, individuals and/or life experiences in your life and practice do you feel have informed your understanding and provision of compassionate care? Have you always been that way? [Were you always like that? How did you learn it? Can it be learned?]
4. If you reflect back on your current position, can you walk me through the best example of when you provided compassionate care? [What constitutes compassionate care in an admin/phone triage role? Please guide me through the process of this encounter in a sequential fashion, highlighting the key components of this interaction from the initial approach to the consequences of this interaction?]
5. Based on your professional and personal experiences, what shapes your compassionate care?
6. If you were responsible for training students in compassionate care, how would you go about it? [What would you teach them?]
7. Is there anything that gets in the way of your ability to provide compassionate care?
8. How do patients and/or families influence how your ability to provide compassionate

care? [What characteristics of patients and/or families, do you feel facilitate or inhibit compassionate care?]

9. A number of participants have identified the healthcare system as being a significant factor in delivering compassionate care? From your perspective, how does/can the healthcare system facilitate or inhibit compassionate care?
10. In light of the things you've just identified as facilitators and barriers, what suggestions would you have for enhancing compassion at a systems level? [Where and what would you focus your efforts on in order to enhance compassion at a systems level?]
11. From what you've told me so far, it sounds like compassionate care is important. So what happens [to patients, families or HCPs] when compassionate care is lacking?
12. What impact does providing compassionate care have on you personally and professionally?
13. Our focus group participants, previous studies and review of the literature have reported how critical and fundamental compassion is to providing quality patient care, but we also know that compassionate care varies. So given all that we know about the importance of compassionate care, why aren't healthcare providers more compassionate?
14. Before we end, given all we've talked about, I just want to revisit one of the first questions I asked, which is how do you personally define compassion? [In light of our discussion, what does compassion mean to you?]
15. Is there anything related to compassion that we have not talked about today that you think is important or were hoping to talk about?

#### Table 4: Stage 3 Focus Group Questions

1. Does the healthcare provider model of compassion make sense to you? [Does it resonate with you]? [Why or Why not]?
2. Do you feel there is anything missing from the model?
3. How do you feel this model might be relevant to you and your work?
4. How do you suggest the model might be integrated into healthcare practice and education?
5. Is there anything related to the model that we have not talked about today that you think is important or were hoping to talk about?

## Data Analysis

This study was guided by Straussian grounded theory, an inductive, iterative, qualitative method that aims to define and construct a theoretical account of a topic grounded in study data within a naturalistic setting.<sup>30 33 34</sup> Five members of the research team with qualitative expertise (SS, TH, SM, SRB, KS) analyzed the data in accordance with the three stages of analysis. The first stage, open coding, involved each individual reading each transcript, line-by-line, recording individual codes in the margin, with subsequent codes being compared and contrasted with previous codes—an analytical process known as the constant comparative technique.<sup>30</sup> After independently analyzing each set of 2-3 transcripts, the analysis team met to compare and contrast codes in a line-by-line fashion through a process of consensus, producing a ‘master’ coded transcript for each interview and focus group. Axial coding, the second stage of analysis, began at a 3-day face-to-face analysis team meeting after Stage 1 focus group data had been analyzed. The purpose of axial coding is to compare codes with other data, to combine and collapse codes, and to cluster codes into categories and themes, generating a coding schema, which was used and modified in subsequent interviews. The third stage of analysis, selective coding involved integrating and refining categories and themes as the theory and core variable began to emerge, allowing researchers to confirm facets of the theory in the remaining interviews. The theoretical model was finalized at a 3-day meeting before being vetted through the study participant and a key stakeholder focus group.

## RESULTS

1  
2  
3 Five related categories and thirteen associated themes emerged from the data (Figure 1).  
4  
5 The core variable, which describes phenomenon of interest and links the categories together, was  
6  
7 *a virtuous, intentional response to know and understand a person and ameliorate their suffering.*  
8  
9  
10 The key dimensions of compassionate care, are illustrated in a theoretical model (Figure 2),  
11  
12 producing a HCP definition of compassion—*A virtuous and intentional response to know a*  
13  
14 *person, to discern their needs, and ameliorate their suffering, through relational understanding*  
15  
16 *and action.*  
17

18  
19 \* **Figure 1. Elements of Compassion: Categories and Themes** (*Please insert here*)  
20

21 \* **Figure 2. Healthcare Provider Compassion Model** (*Please insert here*)  
22  
23

## 24 25 **Virtuous Intent**

26  
27 Participants provided insight into the internal processes that served as the catalyst and  
28  
29 conduit that compassion flowed from and through. Compassion was not simply understood as an  
30  
31 affective response, but a response based in the virtues that participants brought into the clinical  
32  
33 encounter. The Category of Virtuous Intent, *the purposeful desire to embody and express one's*  
34  
35 *good and noble qualities in professional practice*, was described by a number of participants as  
36  
37 an internal process of self/provider congruence.  
38  
39

## 40 41 **Virtues: Personal Qualities**

42  
43 Study participants identified virtues as the primary motivator and medium of compassion.  
44  
45 While most participants believed that every HCP possessed and could cultivate these *good or*  
46  
47 *noble qualities*, they acknowledged variance in these innate qualities based on personal and  
48  
49 professional experiences, willingness, and circumstance. While compassion was conceptualized  
50  
51 as a multi-dimensional construct (Figure 2), associated behaviours and skills had to flow from  
52  
53 and through virtues of love, acceptance, honesty, genuineness, humility and kindness to be  
54  
55  
56  
57  
58  
59

1  
2  
3 considered compassionate in comparison to other expressions of care (e.g. routine care, empathy,  
4  
5 sympathy).

6  
7  
8 Genuine love for your fellow man, that helps you be compassionate and to want to care  
9 for people (Interview Participant 3).

10  
11 When I think of empathy and I think of compassion, I think that compassion is a bit  
12 broader and deeper and more loving (Interview Participant 15).

13  
14 I think you can say the right words, but I think there has to be genuineness behind it.  
15 And I think people pick up on that whether you're acting or not (Interview Participant 7).

### 16 17 18 Presence: Embodied Virtues

19  
20 Presence was understood as *the distillation and expression of personal virtues to others*  
21 *through the character of an individual*. Virtues were not considered static traits according to  
22 participants, but permeated through the presence of HCPs into their practice. Since caregivers  
23 felt that patients could intuitively sense their virtues and capacity for compassion, they  
24 emphasized the importance of self-awareness and developing these inner qualities prior to  
25 interacting with the patient.  
26  
27  
28  
29  
30  
31  
32  
33

34 There's something in the caregiver that resides in the caregiver but it's sort of, there's this  
35 catalytic thing that happens when it comes into the presence of someone else's suffering  
36 and then something could catch fire or not (Stage 1 Focus Group Participant 12)

37  
38  
39 Being genuine, they can see that and they can feel that so... it's almost like an energy that  
40 occurs as well. They can feel it and you can feel it... I always say can I be vulnerable in  
41 their presence and try to equalize it and I don't necessarily disclose my human spirit but I  
42 think I release it in a way that allows them to bring it forward (Stage 1 Focus Group  
43 Participant 23).

44  
45  
46 Before we ever say a word, people feel from us who we are, in these beds and in these  
47 rooms. And that's compassion (Interview Participant 6).

### 48 49 Intention: Embodied Presence

50  
51 Immediately prior to engaging with the person in suffering, many participants described  
52 an intentional practice, whereby they adopted *a self-effacing and curious attitude toward the*  
53  
54  
55  
56  
57  
58  
59

1  
2  
3 *patient and tried to orientate themselves to the patient's perspective.* While the necessity for a  
4 self-effacing attitude to compassionate care was explicitly noted by a number of participants, it  
5 was implicit in the responses of exemplary compassionate caregivers, many of whom upon being  
6 notified that they had been nominated noted that they did not self-identify as being particularly  
7 compassionate. This intentional process of concurrently demoting oneself and trying to take the  
8 perspective of the patient, reflected participants' belief that compassion involves forethought and  
9 choice, whereby HCPs intentionally put aside their frustrations, needs, and wishes and their  
10 preconceptions about the patient in order to practice compassion.  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20

21  
22 Everyone has the possibility to be compassionate. They just have to choose to be  
23 (Interview Participant 1).  
24

25 It's almost like a different intentional way of being that you have to work on or cultivate  
26 (Stage 3 Focus Group Participant 1).  
27

28 I think compassion is about coming with an open, maybe even curious attitude of being  
29 able to be present with another individual... So being able to suspend what's going on for  
30 those few moments when you enter and so, you know it's kind of like you know  
31 envisioning as you approach the door and taking that deep breath and kind of cleansing  
32 yourself to walk into that room (Interview Participant 8).  
33  
34  
35

## 36 **Relational Space**

37  
38 Participants situated the core dimensions of compassionate care within a broader  
39 relational space, which was defined as *the context for compassion where the virtuous intent of*  
40 *the caregiver engages the suffering of a person.* Compassion was reciprocal in that it was  
41 regulated by an openness by patients to receive compassion and a willingness on the part of the  
42 caregiver to be professionally and personally impacted by the suffering of their patients.  
43  
44  
45  
46  
47  
48  
49

50 Compassion involves two people or more I guess, but it's not just sort of one person I am  
51 being---I am exuding compassion. Like I think it needs to be given and received and I  
52 see it as kind of going back and forth. (Interview Participant 8)  
53  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 It's not something that exists just within me. It's something that occurs between me and  
4 somebody else. (Interview Participant 1)  
5

### 6 **Coming to Know the Person**

7  
8  
9 Having established an initial connection to their patient within the relational space HCPs  
10 described an ongoing process of coming to know the person, *an attentive and sensitive approach*  
11 *that seeks to engage, accept, and understand the patient as a person.*  
12  
13

### 14 **Engaging the Patient in a Sensitive Manner**

15  
16  
17 HCPs described the importance of engaging the patient in an attentive and sensitive  
18 manner within the clinical encounter. This involved HCPs *attuning to the energy of the room, the*  
19 *patients' presence, and interpersonal cues in order to be attentive to the person and to develop*  
20 *an awareness of their background.* Many participants felt that this approach, allowed them to  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31 develop an understanding and appreciation of the larger life story which necessitated their ability  
32 to see the patient as a person and accept them where they were at.

32 This is the sensitive part you're matching their energy level for that time that they're in  
33 the hospice or that time you're in that room (Interview Participant 12).  
34

35  
36 Sensitivity would probably be one of the---being able to read a room when you walk into  
37 it and kind of know what's going on or sense what's going on there and be sensitive to  
38 the dynamics that you feel between people there (Interview Participant 1).  
39  
40  
41

### 42 **Seeing the Patient as a Person**

43  
44  
45 In the context of clinical care, participants were emphatic about the importance of  
46 *extending one's vision beyond the illness, the body, and 'the patient' in order to view the person*  
47 *as a fellow human.* Seeing the patient as a person ranged from simple gestures such as asking the  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60 person how they preferred to be addressed, to eliciting the person's story, to allowing the person  
to make care decisions versus telling them what to do.

1  
2  
3 I think what we need to do is we need to see this person as a human being... treat this  
4 person as a human being and not as the patient with diagnosis X, but as a person who has  
5 had all of these lived experiences that is at this place and is feeling this way (Interview  
6 Participant 8).  
7

8  
9 So, you need to look them in the eyes and be soft and kind and like 'I see you behind  
10 there'. And I'm going to take care of you, like I've got you, like I got this (Interview  
11 Participant 15).  
12

13 I think true compassion is you know an understanding individually of what is it that  
14 person wants and needs from us that we can give to them? (Interview Participant 2).  
15  
16

### 17 Accepting The Person Where They Are At 18

19 Participants described a third theme that involved *seeking to understand the person's*  
20 *circumstance and accept them unconditionally in spite of their past and/or present behaviours.*  
21  
22

23 While this primarily involved accepting patient attitudes, behaviours, and frustrations that were  
24 related to their situation, extending unconditional acceptance toward abusive patients or  
25 individuals with a criminal record served as both the greatest challenges to compassion and case  
26 exemplars of their compassionate colleagues.  
27  
28  
29  
30  
31  
32

33 One of the nursing attendants told me one day how he had been with a patient for two  
34 days and this guy had been incontinent of stool and just messed himself again and he was  
35 unsteady and the nursing attendant was supporting the guy and cleaning him up and while  
36 he was back there cleaning the back of his legs his bowels let go again and this  
37 professional, without complaint, began to wash the guy again. And the man turned  
38 around and using a racial epithet cursed him, what are you doing back there you fuck, and  
39 again the man took it with humility and generosity of spirit and didn't strike back with  
40 words or actions but fulfilled his duty. That's a striking story of compassion (Stage 1  
41 Focus Group Participant 4).  
42  
43

44 We've had a holocaust survivor. We've had a German soldier you know, who was  
45 forced into doing things that they didn't want to do.... We have to have compassion all  
46 around for each person (Interview Participant 2).  
47  
48

49 One example that comes to mind is a young woman, who was a prostitute...and I was  
50 working in the OR and people were talking over her in a very disparaging manner...and I  
51 remember my thought at the time was I don't think she thought as a little girl 'Gee, I'd  
52 like to be a prostitute when I grow up'. But stuff happened in her life that that's where  
53 she was (Stage 3 Focus Group Participant 3).  
54  
55  
56  
57  
58  
59  
60

### Forging a Healing Alliance

Although participants felt that compassion did not require a pre-existing relationship, they nonetheless felt that compassion was further forged and optimized through the establishment of a therapeutic relationship-- *a relationship that is nurtured that is cultivated through verbal and non-verbal communication that promotes healing through an in-depth understanding of the person and their unique experiences in order to personalize compassionate care.*

#### Being Present: Demeanor

While time was a factor in forging a healing alliance, participants also felt that it could be quickly established through the demeanor HCPs conveyed within each clinical encounter regardless of its duration. According to a number of participants, demeanor involved attempting to be fully present to the patient and was reflected in the way in which care is given—whereby their demeanor imbued and effected each care interaction.

Because it's not what you do, it's the way you do things for people that is compassion (Stage 1 Focus Group Participant 35).

She's [exemplary compassionate care nominee] fully present in every room and when caring for someone, she makes it seem like they're the only person she has to take care of (Stage 1 Focus Group Participant 24).

He [nominee] provides comfort with his calm and gentle demeanor (Stage 1 Focus Group Participant 15).

#### Relational Communication

Relational communication was described as *the establishment of a deeper understanding of the person and their individualized needs through active listening.* The centrality of listening relative to compassion not only involved listening to what patients said, but listening to the

1  
2  
3 subtext of what is being said— tone of voice, moments of silence, and non-verbal cues that  
4  
5 helped to unmask hidden suffering.  
6

7  
8 I think when people feel heard and they feel like someone actually cares and actually is  
9 taking the time to listen that's what they interpret as being compassionate (Interview  
10 Participant 7).  
11

12 When they call I usually just drop everything and you listen to their tone of voice. I can  
13 hear it when the tears are there you know... there's that pause and I let that pause happen  
14 because they're deciding whether or not they're going to tell me or they're realizing how  
15 overwhelmed they really are (Interview Participant 13).  
16  
17

18 It's listening to what's not being said and recognizing that and really gently making it  
19 okay to talk about those things (Interview Participant 15).  
20

## 21 Therapeutic Relationship

22  
23 The themes of being present and relational communication were instrumental in  
24 establishing a deeper therapeutic relationship which participants described as *a human-to-human*  
25 *connection facilitated through the mutual sharing of stories, feelings, and expressions of care*  
26 *between healthcare providers and their patients in order to promote healing.* Establishing a  
27  
28 therapeutic relationship, extended the largely unidirectional theme of 'Seeing the Patient as a  
29  
30 Person' to a reciprocal level, whereby participants related to their patients from a place of shared  
31  
32 humanity.  
33  
34  
35  
36  
37  
38  
39

40 He [physician nominee] tries to find out who they are and makes time for social visits not  
41 just medical assessments (Stage 1 Focus Group Participant 29).  
42

43 I really wanted to understand, but not from a head space, like from a heart space in terms  
44 of the feeling and really kind of connecting that way with her (Interview Participant 15).  
45  
46

47 I try to have a sense of what story they're living and be able to kind of feel how I can be a  
48 constructive player in that story (Interview Participant 1).  
49  
50

## 51 In-Depth Understanding of the Person

52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 The end outcome within the domain of forging a healing alliance was to come to an in-  
4  
5 depth understanding of the person so that HCPs could optimally address a person's multifactorial  
6  
7 needs in a personalized manner. Coming to an in-depth understanding of the person was  
8  
9 conceptualized as *a deep desire to engross oneself in a person's story in order to determine*  
10  
11 *sources of personal meaning and how these were effected by and contributed to their suffering.*  
12  
13 Whereas the theme of 'Intention' involved emotional resonance (feeling with) in which  
14  
15 participants considered how they would want to be treated if they were in the patient's position,  
16  
17 an in-depth understanding engaged a higher process of 'feeling for' the patient. This involved  
18  
19 moving beyond considering how the HCP would want to be treated if they were the patient, to  
20  
21 having developed an in-depth understanding of the person, and an understanding of how the  
22  
23 patient would want to be treated.  
24  
25  
26  
27

28 The Golden Rule is good to a point, but sometimes somebody else might not want what I  
29 want (Interview Participant 15).

30  
31  
32 What brings meaning to them and it's about how we engage and being able to support  
33 that (Stage 1 Focus Group Participant 30).  
34

### 35 **Ameliorating Suffering**

36  
37 The primacy of action within each of the dimensions of compassion culminated in  
38 participants identifying 'ameliorating suffering' as the ultimate goal of compassion.  
39

40 Ameliorating suffering, was defined as *tangible acts intended to alleviate actual or anticipatory*  
41  
42 *threats to a person's physical, emotional, social and/or spiritual wellbeing.*  
43  
44

### 45 **Discerning Needs**

46  
47  
48  
49 Discerning needs describes *the ability to anticipate, perceive or prioritize health care*  
50  
51 *needs based on knowledge of the person and their circumstance in order to alleviate their*  
52  
53 *suffering.* Discernment ranged from anticipating an impending pain crisis, to recognizing the  
54  
55  
56  
57  
58  
59

1  
2  
3 patient's need for personal space, preparing the patient for a prognostic conversation, demoting  
4  
5 competing system priorities, to prioritizing which patients needed compassion the most.  
6

7  
8 One of the strategies that I usually employ is I try to think about at the beginning of the  
9 day, you know who needs the most time today? And then structure my day accordingly  
10 as much as possible... (Interview Participant 9).  
11

12 The discerning needs piece really resonated with me, thinking back to my days as a  
13 bedside palliative care nurse...it's absolutely true, especially discerning which patients  
14 need more compassion (Stage 3 Focus Group Participant 5).  
15

16  
17 Then that's where anticipatory care is really important, because you're like I've already  
18 thought of that. That's why I just gave him a break-through because he's looking like he  
19 was in pain and he has to go to radiation in half an hour, so follow along (Interview  
20 Participant 4).  
21

## 22 Providing Emotional and Existential Support

23  
24 While compassion traversed the care trajectory, health domains, and the caregiver/patient  
25 relationship, participants also identified key moments where compassion seemed to be essential  
26 or most needed--incidences of suffering that included emotional and existential distress.  
27  
28

29  
30 Providing emotional and existential support involved *allaying uncertainty, fears, and distress*  
31 *that threaten personal existence by eliciting meaningful memories, affirming strengths, and*  
32 *providing supportive touch and words of affirmation.*  
33  
34  
35  
36  
37

38  
39 To me it didn't seem humane that this gentleman was gonna die alone, it just didn't seem  
40 right that he'd had no visitors and now he was gonna leave this world alone. I don't know  
41 if he knew I was there but I just held his hand and talked softly (Stage 1 Focus Group  
42 Participant 3).  
43

44 I'm doing what I'm setting out to do and it's not only my job physically, but it's that  
45 bigger---maybe kind of total... but then there's a psychosocial, spiritual pain that they  
46 can be having (Interview Participant 11).  
47  
48

49 I think that we can have all the words and have all the nice clothes and look like we've  
50 very efficient, but I think it's compassion that shakes the hand of another person and that  
51 rubs their forehead, that opens the door to their heart where they feel safe (Interview  
52 Participant 6).  
53

## 54 Addressing Needs

1  
2  
3 The final theme, addressing needs, involved *a proactive and attuned response to directly*  
4 *engage in and alleviate a person's multifactorial suffering*. Participants felt that compassion  
5  
6 addressed needs primarily in two ways: small acts of compassion within HCPs call of duty; and  
7  
8 extraordinary acts beyond the call of duty. Small acts ranged from exercising diligence and  
9  
10 sensitivity in routine care such as attending to activities of daily living, to having attention to  
11  
12 detail in seemingly perfunctory activities such as filling out patients' paperwork or conveying  
13  
14 patient preferences at shift change. Addressing needs that fell outside of the call of duty or  
15  
16 'going the extra mile' were arguably the greatest indicators of a compassionate HCP and were  
17  
18 the most frequently stated reason that peers provided in nominating their exemplary colleagues.  
19  
20 In many ways, these extraordinary acts functioned as a litmus test to detect whether care was  
21  
22 internally motivated from a place of virtues or an ulterior motivator such as remuneration, duty,  
23  
24 or social desirability.  
25  
26  
27  
28  
29  
30  
31

32 I think that empathy is really understanding the feeling and perspective kind of or what is  
33 happening for that person. I think the compassion is taking that and translating it into an  
34 actionable item (Interview Participant 15).  
35

36 And the little things too, when people are in bed we ask them if they like ice water or  
37 room temperature water and it seems like a pretty minor thing but if you don't really like  
38 ice water and you have a jug of it at your bedside and that's all you have to drink that's  
39 not really compassion (Stage 1 Focus Group Participant 8).  
40  
41

42 It's making sure that their paperwork is done and their paperwork is sent out and  
43 following up on things that maybe got dropped along the way... There's compassion in  
44 that too, because you want to make sure that the road is paved as smoothly for that family  
45 and that patient as possible (Interview Participant 13).  
46  
47

48 They stop at the cafe to get a bowl of soup that they know that that patient likes that bowl  
49 of soup. It has nothing to do with their job but they know that they're not eating and if  
50 they hear them say something that they like, they stop and pick it up....and they sit and  
51 eat with them (Stage 1 Focus Group Participant 29).  
52  
53  
54

## 55 DISCUSSION

56  
57  
58  
59  
60

1  
2  
3 Although compassion is an increasing topic of discussion within healthcare, particularly  
4 when it is lacking, the concept has been largely limited to the theoretical realm with limited  
5 clinical studies describing how compassion is operationalized in practice. The HCP Compassion  
6 Model, delineating the key domains of this dynamic construct not only addresses this theory-  
7 practice gap, but can serve as pragmatic tool for evidence informed practice and as an empirical  
8 foundation for future studies in this area.  
9

10  
11  
12 This study conceptualized compassion within healthcare from the perspective of HCPs,  
13 extending previous research on patients' perspectives.<sup>10</sup> While we had anticipated that the HCP  
14 Compassion Model would be depicted in a distinct fashion, our analysis revealed that while there  
15 were some differences embedded within the themes and categories, the overarching structure  
16 mirrors the Patient Compassion Model—illustrating the flipside of the compassion dyad (Figure  
17 2). This was further verified by Stage 3 participants, who while endorsing the structure and  
18 temporal flow of compassion depicted in the model, paralleling the clinical process of  
19 approaching the bedside, making an initial relational connection, getting to know the person,  
20 forging a therapeutic alliance, and ameliorating suffering, they cautioned against a strict stepwise  
21 conceptualization of compassion, noting that in reality there was an oscillation between and  
22 within the themes within each category. Further, while the 5 categories and 13 themes illustrating  
23 the key domains of compassion need to be working in tandem for care to be considered  
24 compassionate, Stage 3 participants noted that certain domains are likely to be more prominent  
25 in some encounters as determined by patient need or condition. For example, while forging a  
26 therapeutic relationship with an incapacitated patient may not be possible, HCPs felt they were  
27 still able to express compassion through alternate pathways within the model. As such, while the  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 model illustrates a logical linear flow of compassion, it also recognizes compassion as dynamic,  
4  
5 ebbing and flowing as necessary.  
6

7  
8 As expected, HCP participants provided insight into the internalized processes of  
9  
10 compassion, which patients in our previous study could only postulate due to their limited  
11  
12 perspective as the recipients of compassionate care. At a categorical level these new findings  
13  
14 resulted in the emergence of the broader category of 'Forging a Healing Alliance', with  
15  
16 'Relational Communication' being subsumed as a theme within it. HCP participants described a  
17  
18 deeper process, inclusive of, but not limited to, relational communication, both in terms of intent  
19  
20 and effect. This was illustrated further in the additional theme of 'Therapeutic Relationship',  
21  
22 which along with Demeanor and Relational Communication sought to come to an in-depth  
23  
24 understanding of the individual, affirming research in the field of psychology.<sup>13 35</sup> Additionally,  
25  
26 a more fulsome understanding of compassion at a thematic level emerged from this study, as  
27  
28 according to HCPs, compassion was not a bolus or systemic form of caring, but an intentional,  
29  
30 discerning and targeted modality. As a result of these additional findings, we suggest that  
31  
32 compassion may be conceptualized as the medium of 'personalized healthcare', extending the  
33  
34 concept of personalized medicine that focuses on the treatment of disease,<sup>36</sup> to each interaction  
35  
36 the patient has with their HCPs.  
37  
38  
39  
40  
41

42 The additional themes of 'Discerning needs' and 'Intention' raise a number of additional  
43  
44 questions regarding the unconditional nature of compassion. Previous research identified  
45  
46 compassion as largely being an unconditional care construct, in comparison to the conditional  
47  
48 nature of sympathy, which is mediated by the self-preservation of the caregiver, and empathy,  
49  
50 which is effected by perceived relatedness and deservedness.<sup>31 37 38</sup> According to HCPs,  
51  
52 compassion involved bringing an open mind and not simply an empty head to each patient  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 encounter,<sup>25 39</sup> echoing Wilber's summation that, "real compassion includes wisdom and so it  
4 makes judgments of care and concern".<sup>40</sup> Results from this study suggest that reasoning,  
5  
6 however, as it relates to compassion assesses individuals' needs and seeks to understand the  
7  
8 person, in contrast to other care constructs that seem to focus on assessing the individual and  
9  
10 allowing this to determine whether to act accordingly. In a similar vein, participants'  
11  
12 identification that compassion involved choice, is further evidence that while compassion  
13  
14 involves cognitive processing, this does not necessarily equate with being selective. Rather, the  
15  
16 practice of intentionality, involved exposing and counteracting these subconscious conditions  
17  
18 and barriers in order to accept the person in an unconditional manner—expanding ones' capacity  
19  
20 for compassion in the process. This study also provides further insight into the relationship  
21  
22 between empathy and compassion, which builds on previous patient-orientated research.<sup>31</sup> In  
23  
24 contrast to recent research that has depicted the relationship between these constructs in either a  
25  
26 conflated or dichotomous manner,<sup>11 20 22 26 37 41</sup> this study suggests that 'feeling with' in relation  
27  
28 to compassion is a necessary touch-point facilitating higher, more sustainable states of 'feeling  
29  
30 for' and 'doing for', in contrast to empathy where it functions as an endpoint.<sup>31 39</sup>

31  
32  
33 One of the surprising findings of this study was the identification of virtues, the good and  
34  
35 noble qualities embedded within the character of HCPs, as the primary motivator of  
36  
37 compassion—unexpectedly replicating the results of our patient study.<sup>10</sup> While patients'  
38  
39 perceptions of the internal motivators of compassion within their HCPs were novel, it  
40  
41 nonetheless required the verification of HCPs to determine whether this assumption was in fact  
42  
43 accurate. A number of HCPs went so far as to describe compassion as a process of self/provider  
44  
45 congruence, whereby they attempted to integrate and cultivate these noble personal qualities into  
46  
47 their professional practice.<sup>42</sup>

## Strengths and Limitations

While the results of this study provide the foundation for a comprehensive understanding of compassion from the perspective of those who provide it, it is not without limitations.

Although our study sample was recruited across a variety of settings, all participants worked in palliative care and therefore, there may be variance to the model in other fields of healthcare.

Further, while the snowball sampling technique of Stage 1 participants nominating Stage 2 interviewees was novel and largely beneficial, it nonetheless may have diminished the heterogeneity of the sample, as participants may have inadvertently nominated like-minded individuals. Finally, while participants identified behaviours that were associated with compassion, these were not verified by observational data.

## Implications for Research, Policy and Clinical Practice

The HCP Compassion Model has a number of implications for research and clinical practice. The model provides a robust and comprehensive foundation of compassionate care, to inform the development of a patient reported compassion measure, addressing a considerable research and practice gap in the process.<sup>43</sup> It also provides HCPs with key clinical tools that they can draw upon in order to cultivate the requisite skills, behaviours, and qualities to enhance compassionate care to others in their practice. While it is anticipated that the utilization of certain facets of the compassion model will be influenced by HCP comfort level, discipline, and personality, both our current and previous study participants were adamant that compassion was a multidimensional construct, thus guarding against a unidimensional approach that only emphasized certain domains or themes based on individual preference.

## Conclusions

1  
2  
3           Compassion should not be construed as a ‘one size fits all’ approach as it is predicated on  
4  
5 the personal virtues that HCPs bring to their clinical practice, adapts to the person and their  
6  
7 individualized needs, and is uniquely expressed by each HCP. Nonetheless, compassion requires  
8  
9 HCPs to consider the various facets of compassion within their area of specialized expertise,  
10  
11 recognizing that while mastery is unattainable, the multidimensional facets of compassion can be  
12  
13 cultivated through practice.  
14  
15

### 16 17 18 19 **Disclosures and Acknowledgements**

20  
21 Contributors: All nine authors fulfill all four of the International Committee of Medical Journal  
22  
23 Editors guidelines for authorship. SS, SRB, TH, SM, KS, AS, NH and HMC conceptualized the  
24  
25 study. SS supervised PS who managed, acquired, cleaned and coordinated analysis of the data.  
26  
27 SS, SRB, TH, SM, KS and PS analyzed interview and focus group data. All authors contributed  
28  
29 to the final draft and approved the final version for publication.  
30  
31

32  
33 Acknowledgements: We would like to acknowledge Kate Beamer, research assistant, for her  
34  
35 dedication and commitment to this study. We would also like to acknowledge and thank the  
36  
37 research participants who generously shared their time, wisdom, experiences and enthusiasm on  
38  
39 the topic.  
40  
41

42 Data Sharing Statement: No additional data are available  
43

44 Funding Statement: This study was supported by a MSI Foundation Grant, (Grant #880).  
45

46 Competing Interest Statement: The authors declare no conflicts of interest.  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## References:

1. American Medical Association. Code of medical ethics 2006 [Available from: <https://www.ama-assn.org/about-us/code-medical-ethics> accessed 23 February 2017.
2. Department of Health. Confidence in caring: A framework for best practice. 2008 [Available from: [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086387?IdcService=GET\\_FILE&dID=144574&Rendition=Web](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086387?IdcService=GET_FILE&dID=144574&Rendition=Web) accessed August 4 2017.
3. Flocke SA, Miller WL, Crabtree BF. Relationships between physician practice style, patient satisfaction, and attributes of primary care. *J Fam Pract* 2002;51(10):835-40.
4. Paterson R. Can we mandate compassion? *Hastings Center Report*;41(2):20-3.
5. MacLean L. The Vale of Leven Hospital Inquiry Report 2014 [Available from: <http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf> accessed May 2 2017.
6. The Willis Commission. Quality with compassion: the future of nursing education. Report of the Willis Commission on Nursing Education 2012 [Available from: <https://www.nursingtimes.net/download?ac=1255026> accessed May 2 2017.
7. Department of Health. More care, less pathway- A review of the Liverpool care pathway 2013 [Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212450/Liverpool\\_Care\\_Pathway.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf) accessed May 2 2017.
8. Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry The Stationary Office: London, England; 2013 [updated 2013//. Available from: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry> accessed August 4 2017.
9. Sinclair S, Norris JM, McConnell SJ, et al. Compassion: a scoping review of the healthcare literature. *BMC Palliat Care* 2016;15:6. doi: 10.1186/s12904-016-0080-0
10. Sinclair S, McClement S, Raffin-Bouchal S, et al. Compassion in Health Care: An Empirical Model. *J Pain Symptom Manage* 2016;51(2):193-203. doi: 10.1016/j.jpainsymman.2015.10.009
11. Papadopoulos I, Taylor G, Ali S, et al. Exploring Nurses' Meaning and Experiences of Compassion: An International Online Survey Involving 15 Countries. *J Transcult Nurs* 2015 doi: 10.1177/1043659615624740
12. Papadopoulos I, Zorba A, Koulouglioti C, et al. International study on nurses' views and experiences of compassion. *Int Nurs Rev* 2016;63(3):395-405. doi: 10.1111/inr.12298
13. Vivino BL, Thompson BJ, Hill CE, et al. Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research* 2009;19(2):157-71.
14. Way D, Tracy SJ. Conceptualizing compassion as recognizing, relating and (re) acting: A qualitative study of compassionate communication at hospice. *ComM* 2012;79
15. Ghaljeh M, Iranmanesh S, Nayeri ND, et al. Compassion and care at the end of life: oncology nurses' experiences in South-East Iran. *International Journal of Palliative Nursing*;22(12):588-97.

16. Lown BA, Rosen J, Marttila J. An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health Aff (Millwood)* 2011;30 doi: 10.1377/hlthaff.2011.0539
17. Graber DR, Mitcham MD. Compassionate clinicians: take patient care beyond the ordinary. *Holist Nurs Pract* 2004;18(2):87-94.
18. Kvangarsnes M, Torheim H, Hole T, et al. Nurses' perspectives on compassionate care for patients with exacerbated chronic obstructive pulmonary disease. *J Allergy Ther* 2013;4 doi: 10.4172/2155-6121.1000158
19. Lloyd M, Carson A. Making compassion count: Equal recognition and authentic involvement in mental health care. *Int J Consumer Stud* 2011;35 doi: 10.1111/j.1470-6431.2011.01018.x
20. Bray L, O'Brien MR, Kirton J, et al. The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students. *Nurse Educ Today* 2014;34 doi: 10.1016/j.nedt.2013.06.017
21. Van Der Cingel M. Compassion in care: a qualitative study of older people with a chronic disease and nurses. *Nurs Ethics* 2011;18(5):672-85. doi: 10.1177/0969733011403556
22. Armstrong AE, Parsons S, Barker PJ. An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study. *J Psychiatr Ment Health Nurs* 2000;7(4):297-305.
23. Skaff KO, Toumey CP, Rapp D, et al. Measuring compassion in physician assistants. *JAAPA* 2003;16
24. Horsburgh D, Ross J. Care and compassion: the experiences of newly qualified staff nurses. *J Clin Nurs* 2013;22(7-8):1124-32. doi: 10.1111/jocn.12141
25. Department of Health. Compassion in Practice. Nursing, Midwifery and Care Staff. Our Vision and Strategy 2012 [Available from: <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> accessed May 2 2017.
26. Kneafsey R, Brown S, Sein K, et al. A qualitative study of key stakeholders' perspectives on compassion in healthcare and the development of a framework for compassionate interpersonal relations. *J Clin Nurs* 2016;25(1-2):70-9. doi: 10.1111/jocn.12964
27. R. F. Report of the Mid Staffordshire NHS Foundation Trust public inquiry. *London: The Stationary office* 2013
28. Callwood A, Cooke D, Allan H. Developing and piloting the multiple mini-interview in pre-registration student midwife selection in a UK setting. *Nurse Educ Today* 2014;34(12):1450-4. doi: 10.1016/j.nedt.2014.04.023
29. Willis L. Raising the Bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants 2015 [accessed May 2 2017.
30. Strauss AL, Corbin JM. Basics of qualitative research : grounded theory procedures and techniques. Newbury Park, Calif.: Sage Publications 1990.
31. Sinclair S, Beamer K, Hack TF, et al. Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliat Med* 2017;31(5):437-47. doi: 10.1177/0269216316663499
32. Sinclair S, Torres MB, Raffin-Bouchal S, et al. Compassion training in healthcare: what are patients' perspectives on training healthcare providers? *BMC Med Educ* 2016;16:169. doi: 10.1186/s12909-016-0695-0

- 1  
2  
3 33. Glaser BG, Strauss AL. The discovery of grounded theory; strategies for qualitative research.  
4 Chicago,: Aldine Pub. Co. 1967.  
5 34. Corbin JM, Strauss AL. Basics of qualitative research : techniques and procedures for  
6 developing grounded theory. Fourth edition. ed. Los Angeles: SAGE 2015.  
7 35. Gilbert P. The origins and nature of compassion focused therapy. *Br J Clin Psychol* 2014;53  
8 doi: 10.1111/bjc.12043  
9 36. Smith R. Stratified, personalised, or precision medicine. *The BMJ Opinion* 2012  
10 37. Singer T, Klimecki OM. Empathy and compassion. *Curr Biol* 2014;24(18):R875-8. doi:  
11 10.1016/j.cub.2014.06.054  
12 38. Post SG, Ng LE, Fischel JE, et al. Routine, empathic and compassionate patient care:  
13 definitions, development, obstacles, education and beneficiaries. *J Eval Clin Pract*  
14 2014;20(6):872-80. doi: 10.1111/jep.12243  
15 39. Bloom P. Against Empathy: The Case for Rational Compassion: Harper Collins: New York  
16 2016.  
17 40. Wilber K. One Taste: Daily Reflections on Integral Spirituality: Shambhala Publications  
18 2000.  
19 41. Klimecki O, Singer T. Empathic Distress Fatigue Rather Than Compassion Fatigue?  
20 Integrating Findings from Empathy Research in Psychology and Social Neuroscience:  
21 Pathological Altruism 2011.  
22 42. Rogers CR. A Theory of Therapy, Personality, and Interpersonal Relationships: As  
23 Developed in the Client-centered Framework: New York, NY: McGraw-Hill 1959.  
24 43. Sinclair S, Russell LB, Hack TF, et al. Measuring Compassion in Healthcare: A  
25 Comprehensive and Critical Review. *The Patient: Patient Centred Outcomes Research*  
26 2016 doi: 10.1007/s40271-016-0209-5  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

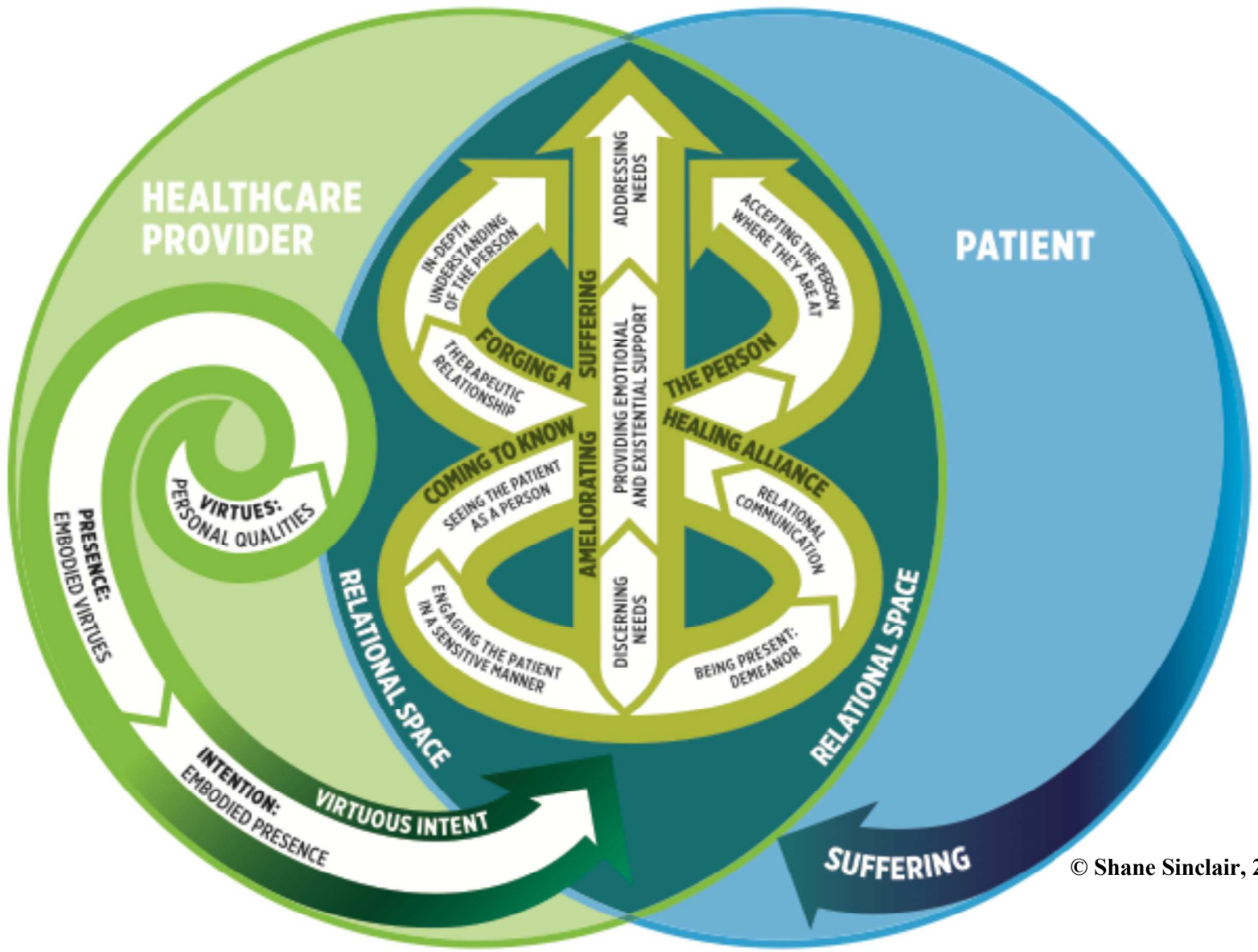


**Figure 1. Elements of Compassion: Categories and Themes**

Category	Theme
Virtuous Intent	Virtues: Personal Qualities
	Presence: Embodied Virtues
	Intention: Embodied Presence
Relational Space	
Coming to Know The Person	Engaging the Patient in a Sensitive Manner
	Seeing the Patient as a Person
	Accepting The Person Where They Are At
Forging a Healing Alliance	Being Present: Demeanor
	Relational Communication
	Therapeutic Relationship
	In-Depth Understanding of the Person
Ameliorating Suffering	Discerning Needs
	Providing Emotional and Existential Support
	Addressing Needs



Figure 2. Healthcare Provider Compassion Model



© Shane Sinclair, 2017

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

**Table 1**

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
<b>Domain 1: Research team and reflexivity</b>		
Personal Characteristics		
1.	Interviewer/facilitator or	Which author/s conducted the interview or focus group? <i>The corresponding author (SS) and a research assistant</i>
2.	Credentials	What were the researcher's credentials? (E.g. PhD, MD) <i>. The research team consisted of 7 PhD trained researchers (SS, TH, SM, SRB, KS, HMC, PS) (5 of whom were experts in qualitative methods (SS, TH, SM, SRB, KS) ); 2 palliative care MD (NH, AS)</i>
3.	Occupation	What was their occupation at the time of the study? <i>All of the research team had academic appointments, while one researcher (AS) also had a clinical position working on a palliative care unit in Alberta Health Services.</i>
4.	Gender	Was the researcher male or female? <i>The research assistant was a female. The research team consisted of 6 males, and 3 females.</i>
5.	Experience and training	What experience or training did the researcher have? <i>The research team has conducted a number of large qualitative studies utilizing grounded theory, ethnography and hermeneutics in addition to a track record conducting large multicenter trials.. The research assistant has considerable experience conducting qualitative interviews.</i>
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement? <i>No</i>
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? (e.g. personal goals, reasons for doing the research) <i>No information was given to the participants about the</i>

		<i>researcher</i>
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? (e.g. <i>Bias, assumptions, reasons and interests in the research topic</i> ) <i>None.</i>
<b>Domain 2: study design</b>		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? (e.g. <i>grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i> ) <i>Grounded theory</i>
Participant selection		
10.	Sampling	How were participants selected? e.g. <i>purposive, convenience, consecutive, snowball</i> Participants were first informed about the study from through a education session and posters.
11.	Method of approach	How were participants approached? (e.g. <i>face-to-face, telephone, mail, email</i> ) <i>Convenience, snowball and theoretical sampling (Grounded Theory) were utilized.</i>
12.	Sample size	How many participants were in the study? <i>A total of 57 participants participated in the study</i>
13.	Non-participation	How many people refused to participate or dropped out? Reasons? <i>None</i>
Setting		
14.	Setting of data collection	Where was the data collected? e.g. <i>home, clinic, workplace</i> <i>All data was collected in a private room at participants places of work (hospice, home care offices, hospital unit)</i>
15.	Presence of non-participants	Was anyone else present besides the participants and researchers? <i>No</i>
16.	Description of sample	What are the important characteristics of the sample? e.g. <i>demographic data, date</i> <i>The sample is largely representative of a interdisciplinary healthcare team. 86% were female. Average years in palliative care was 11.8 years. A cross-section of Nurses, Physicians and other members of the healthcare team are represented.</i>
Data		

1	collection		
2			
3			
4	17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested? <i>The interview followed an interview guide for each of the three stages. As it was semi-structured, probing questions were used when appropriate to delve more into an area of topical interest</i>
5			
6			
7			
8			
9			
10			
11	18.	Repeat interviews	Were repeat interviews carried out? If yes, how many? <i>No. However some of the Stage 2 interview participants who were nominated by stage 1 focus group members (Snowball sampling) also participated in the focus groups (n=3).</i>
12			
13			
14			
15			
16			
17	19.	Audio/visual recording	Did the research use audio or visual recording to collect the data? <i>All interviews were audio-recorded then given to a transcriptionist. All participants were made aware of the recording prior to signing the informed consent form</i>
18			
19			
20			
21			
22			
23	20.	Field notes	Were field notes made during and/or after the interview or focus group? <i>The interviewer recorded field notes of non-verbal cues throughout the interview</i>
24			
25			
26			
27			
28	21.	Duration	What was the duration of the interviews or focus group? <i>Interviews lasted for 1 – 1 ½ hours</i>
29			
30	22.	Data saturation	Was data saturation discussed? <i>Yes. This was estimated during the design phase of the study, revisited after 25 interviews were conducted and reached after 7 focus groups (n=35) and 15 individual interviews.</i>
31			
32			
33			
34			
35	23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction? <i>Transcripts were independently verified against the audio file by both the transcriptionist and the research assistant. When questions of clarification were needed about individual participants response the research assistant contacted the participant. As grounded theory is an iterative research method participant responses in the initial focus groups and interviews were followed up with subsequent participants as necessary. We also had a dedicated stage that involved member checking with a small sample of participants.</i>
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50	<b>Domain 3:</b>		
51	<b>analysis and</b>		
52	<b>findings</b>		
53	Data analysis		
54	24.	Number of data coders	How many data coders coded the data? The analysis team consisted of 5 coders (SS, TH, SM,
55			
56			
57			
58			
59			
60			

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

SRB, KS)		
25.	Description of the coding tree	Did authors provide a description of the coding tree? <i>No. Authors adhered to grounded theory methods by using the 3 stages of Straussian grounded theory</i>
26.	Derivation of themes	Were themes identified in advance or derived from the data? <i>All themes were derived from the data</i>
27.	Software	What software, if applicable, was used to manage the data? <i>No software was used for coding</i>
28.	Participant checking	Did participants provide feedback on the findings? <i>Yes, as mentioned above (#23), we contacted study participants directly to verify data as necessary. We also had an intentional member-checking focus group with a group of study participants related to the compassion model and to ensure that we had accurately represented their views (Stage 3).</i>
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? (e.g. participant number) <i>Yes, participant quotation were use to support / illustrate the findings. All participants were referred to by a number to maintain participant anonymity</i>
30.	Data and findings consistent	Was there consistency between the data presented and the findings? <i>yes</i>
31.	Clarity of major themes	Were major themes clearly presented in the findings? <i>Yes both major themes and subthemes were presented in the results</i>
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes? <i>Yes, all themes and subthemes were addressed and discussed</i>

# BMJ Open

## What are Healthcare Providers' Understandings and Experiences of Compassion? The Healthcare Compassion Model: A Grounded Theory Study of Healthcare Providers in Canada

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2017-019701.R1
Article Type:	Research
Date Submitted by the Author:	05-Dec-2017
Complete List of Authors:	Sinclair, Shane; University of Calgary, Faculty of Nursing; University of Calgary Cumming School of Medicine, Palliative Care Hack, Thomas; University of Manitoba, Rady Faculty of Health Sciences; University of Central Lancashire, School of Health Sciences Raffin, Shelley; University of Calgary, Nursing McClement, Susan; University of Manitoba, Rady Faculty of Health Sciences; CancerCare Manitoba, Research Institute in Oncology Hematology Stajduhar, Kelli ; University of Victoria, School of Nursing and Institute on Aging and Lifelong Health Singh, Pavneet; University of Calgary, Faculty of Nursing Hagen, Neil; University of Calgary, Oncology, Cumming School of Medicine; University of Calgary Cumming School of Medicine, Clinical Neurosciences and Medicine Sinnarajah, Aynharan; University of Calgary, Palliative Care Chochinov, Harvey Max; University of Manitoba, Psychiatry; CancerCare Manitoba, Research Institute in Oncology Hematology
<b>Primary Subject Heading</b>:	Patient-centred medicine
Secondary Subject Heading:	Qualitative research, General practice / Family practice, Communication, Palliative care
Keywords:	compassion, compassionate care, grounded theory, healthcare providers, model, QUALITATIVE RESEARCH

SCHOLARONE™  
Manuscripts



1  
2  
3 What are Healthcare Providers' Understandings and Experiences of Compassion? The  
4  
5 Healthcare Compassion Model: A Grounded Theory Study of Healthcare Providers in Canada  
6  
7  
8

9 Shane Sinclair PhD,<sup>1,2</sup> Thomas F. Hack PhD,<sup>3,4,5</sup> Shelley Raffin-Bouchal PhD,<sup>1</sup> Susan  
10 McClement PhD,<sup>3,4</sup> Kelli Stajduhar PhD<sup>6</sup>, Pavneet Singh PhD<sup>1</sup>, Neil A. Hagen MD, FRCPC,<sup>2,8</sup>  
11 Aynharan Sinnarajah MD MPH CCFP (PC),<sup>2,7</sup> Harvey Max Chochinov MD, PhD, FRCPC,  
12 FRSC<sup>3,9</sup>  
13  
14  
15

- 16 1. Faculty of Nursing, University of Calgary, 2500 University Drive NW Calgary, Alberta  
17 Canada. T2N 1N4.
- 18 2. Department of Oncology, Cumming School of Medicine, University of Calgary, 2500  
19 University Drive NW, Calgary, Alberta, Canada. T2N 1N4.
- 20 3. Research Institute in Oncology Hematology, Cancer Care Manitoba, 4005E – 675  
21 McDermot, Winnipeg, Manitoba, Canada. R3E 0V9.
- 22 4. College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, 89 Curry  
23 Place, Winnipeg, Manitoba, Canada. R3T 2N2.
- 24 5. School of Health Sciences, University of Central Lancashire, Brook Building (4<sup>th</sup> Floor,  
25 Room BB440), Preston, United Kingdom PR1 2HE
- 26 6. School of Nursing and Institute on Aging and Lifelong Health, University of Victoria, R  
27 Hut, Room 103, Victoria, British Columbia, Canada. V8P 5C2.
- 28 7. Palliative / End of Life Care, Calgary Zone, Alberta Health Services, 710 South Tower,  
29 1403 – 29<sup>th</sup> Street NW, Calgary, Alberta, Canada. T2N 2T8.
- 30 8. Departments of Clinical Neurosciences and Medicine, Cumming School of Medicine,  
31 University of Calgary, 2500 University Drive NW, Calgary, Alberta, Canada. T2N 1N4.
- 32 9. Department of Psychiatry, University of Manitoba, 771 Bannatyne Avenue, Winnipeg,  
33 Manitoba, Canada. R3E 3N4.  
34  
35  
36

37  
38 Word Count: 3874 (excluding title page, abstract, references, figures, tables and participant  
39 quotes). 5600 (including participant quotes).  
40

41 Keywords: compassion; compassionate care; grounded theory; healthcare providers; model;  
42 qualitative  
43

44 Corresponding author: Dr. Shane Sinclair

45 Address: Faculty of Nursing, University of Calgary,  
46 PF 2280, 2500 University Drive NW Calgary, Alberta Canada. T2N 1N4

47 Tel: 403.220.2925

48 e-mail: [sinclair@ucalgary.ca](mailto:sinclair@ucalgary.ca)

49 fax: 403.284.4803  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## ABSTRACT

**Background:** Healthcare providers are considered the primary conduit of compassion in healthcare. Although most healthcare providers desire to provide compassion, and patients and families expect to receive it, an evidence based understanding of the construct and its associated dimensions from the perspective of healthcare providers is needed.

**Objectives:** The aim of this study was to investigate healthcare providers' perspectives and experiences of compassion in order to generate an empirically derived, clinically informed, theoretical model.

**Design:** Data was collected via focus groups with frontline healthcare providers and interviews with peer-nominated exemplary compassionate healthcare providers. Data was independently and collectively analyzed by the research team in accordance with Straussian grounded theory.

**Setting and Participants:** 57 healthcare providers were recruited from urban and rural palliative care services spanning hospice, homecare, hospital based consult teams, and a dedicated inpatient unit within Alberta, Canada.

**Results:** Five categories and 13 associated themes were identified, illustrated in the Healthcare Provider Compassion Model depicting the dimensions of compassion and their relationship to one another. Compassion was conceptualized as -- A virtuous and intentional response to know a person, to discern their needs, and ameliorate their suffering through relational understanding and action.

**Conclusions:** An empirical foundation of healthcare providers' perspectives on providing compassionate care was generated. While the dimensions of the Healthcare Provider Compassion



1  
2  
3 Model were congruent with the previously developed Patient Model, further insight into  
4  
5 compassion is now evident. The Healthcare Provider Compassion Model provides a model to  
6  
7 guide clinical practice and research focused on developing interventions, measures, and  
8  
9 resources to improve it.  
10  
11

12  
13 Keywords: compassion; compassionate care; grounded theory; healthcare providers; model;  
14  
15 qualitative  
16  
17

### 18 19 **Strengths and limitations of this study:**

- 20  
21 • This grounded theory study delineates the key dimensions of compassion from direct  
22 reports of a large qualitative sample (n=57) consisting of frontline healthcare providers,  
23 nominated exemplary compassionate healthcare providers, and key stakeholders across  
24 three distinct data collection phases.  
25  
26
- 27  
28 • A healthcare provider definition and theoretical model of compassion extends the largely  
29 theoretical nature of the compassion literature to a clinically informed and clinically  
30 relevant model that can serve as a framework for policy, practice, education and research.  
31  
32
- 33  
34 • By recruiting healthcare providers working primarily in palliative care, variance in  
35 perspectives and experiences of compassion based on other practice settings, patient  
36 populations, subspecialties and cultures were not captured.  
37  
38
- 39  
40 • By using purposive, snowball and theoretical sampling techniques, our sample may have  
41 been overly represented by like-minded individuals who had an affinity toward the topic  
42 and their ability to provide compassion.  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## BACKGROUND

Compassion is considered a vital component of quality healthcare. Healthcare providers (HCPs) are increasingly recognized as the primary, front line conduits of compassionate care, and not surprisingly, the first target of criticism when compassion is lacking.<sup>1-8</sup> Despite their instrumental role in delivering compassionate care within the healthcare system, research investigating HCPs' understandings and experiences of providing compassionate care directly is nascent.<sup>9</sup> Work investigating nursing<sup>10-13</sup> and physician perspectives<sup>14 15</sup> have begun to advance the field from what was previously a largely theoretical body of knowledge toward an evidence and clinically informed field of research. The current study is aimed to extend this work in order to develop an empirically derived, clinically informed, theoretical model of compassion. It intends to outline key dimensions of compassionate care in the context of healthcare and also to characterize the nature of compassion from the perspective of interdisciplinary healthcare providers who are charged and challenged to provide it. Earlier research largely utilize *a priori* definitions of compassion, or definitions based on factors or situations HCPs associate with compassion. In contrast we began by asking HCPs directly about their understanding of compassion. Obtaining direct participant reports on the construct of interest is recognized as an important step in establishing construct validity particularly for subjective and relational constructs such as compassion,<sup>16-18</sup> significantly affecting the models, measures and research that are produced from them.

Recently, our research team identified a similar research need — a lack of direct patient accounts on the nature of compassion in healthcare – leading to the development of an empirically derived, patient informed, theoretical model of compassion.<sup>19</sup> This study generated the following patient informed definition of compassion : “a virtuous response that seeks to

1  
2  
3 address the suffering and needs of a person through relational understanding and action”.<sup>19</sup> Much  
4 like the dearth of patient perspectives in the literature, we were able to identify only a few studies  
5 investigating HCP perspectives of compassion, most of which utilized predetermined researcher  
6 generated definitions rather than establishing construct validity from the perspective of  
7 individuals actually involved in providing compassion.<sup>10 11 13 20 21</sup> Together, these and other  
8 published studies identified a wide array of behaviours, skills, and attitudes associated with  
9 compassion at the bedside including: relating to the patient as an individual;<sup>21-26</sup> re-acting to  
10 suffering;<sup>13 21 27</sup> presence;<sup>13</sup> giving time and listening,<sup>13 23 28 29</sup> understanding patients’ feelings,<sup>13</sup>  
11 <sup>28 30</sup> confronting,<sup>13</sup> caring,<sup>13</sup> a moral virtue;<sup>28</sup> intelligent kindness;<sup>31</sup> empathy,<sup>11 27 28 30</sup> assisting  
12 patients to make their own decisions,<sup>28</sup> acting in patients’ best interests.<sup>28</sup> In the few studies that  
13 asked participants to define compassion directly, psychotherapists identified it as “connecting the  
14 clients suffering and promoting change through action”.<sup>20</sup> A group of healthcare stakeholders  
15 defined compassion as “the combination of underpinning emotions (such a as sympathy and  
16 empathy), with altruistic values (particularly a desire to help others), which together motivated  
17 an individual to take action that would ultimately be experienced as ‘care by the recipient’”.<sup>32</sup>  
18 While these studies provide insight into conceptualizations of compassion from the perspective  
19 of providers, they are yet limited in their: representativeness of interdisciplinary perspectives;  
20 specificity in identifying the key dimensions of compassion and their relationship to one another;  
21 delineation of compassion to related concepts such as care, empathy and sympathy; and  
22 methodological rigor.<sup>9 33 34</sup>

23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49 The consequences of these issues extend beyond the realm of scholarship, having direct  
50 application to healthcare education and practice. Increasingly, governments, patients, and  
51 healthcare institutions consider compassion a clinical necessity. Compassion has been considered  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 a standard of care,<sup>4 35</sup> an admission requirement for healthcare education,<sup>35-37</sup> and a practice  
4  
5 competency.<sup>2 35</sup> As a result, educators, HCPs and trainees are encouraged, expected, and  
6  
7 increasingly held accountable for their competency in providing compassion – but as yet without  
8  
9 the benefit of a rubric defining and delineating the key attitudes, knowledge, skills and  
10  
11 behaviours that are to be taught and learned.  
12  
13

14  
15 To address these gaps, this grounded theory study investigated the perspectives and  
16  
17 experiences of HCPs on the construct of compassion, in order to develop a theoretical model  
18  
19 illustrating its key dimensions and their relationship to one another.  
20

## 21 **METHODS**

### 22 **Study population**

23  
24  
25 After receiving approval to conduct this study from the University of Calgary Conjoint  
26  
27 Health Research Ethics Board (#REB 15-1999), HCPs were recruited through convenience  
28  
29 sampling, snowball sampling, and theoretical sampling.<sup>38</sup> With these techniques, certain types of  
30  
31 participants (gender, ethnicity, profession) are sampled to ensure a heterogeneous sample and to  
32  
33 address gaps or under developed facets of the emerging theory (such as underdeveloped  
34  
35 categories or themes, and unanticipated findings). HCPs were recruited between October 2015  
36  
37 and September 2016 from the palliative care services of the Calgary Zone in Alberta, Canada.  
38  
39 The services include urban and rural hospice, homecare, hospital based consult teams, and a  
40  
41 dedicated inpatient palliative care unit. HCPs were eligible to participate if they: i) were at least  
42  
43 18 years of age; ii) were able to read and speak English; iii) worked in palliative care for at least  
44  
45 6 months; and iv) were able to provide written informed consent. Participants' questions or  
46  
47 concerns were addressed, and consent was obtained prior to participation in focus groups and  
48  
49 interviews. Although sample sizes are not predetermined in qualitative studies, based on our own  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

research involving similar methodology,<sup>19 39 40</sup> we aimed to recruit approximately 50 HCPs.  
Ultimately, 57 participants were required to reach data saturation (Table 1).

For peer review only

**Table 1: Demographic Information** (Numbers expressed as percentages and (n))

<b>Mean Age (Years)</b>	48.6
Men	14 (8)
Women	86 (49)
<b>Mean number of years in palliative care (range)</b>	11.8
<b>Employment Status*</b>	
Full-time	57.8 (33)
Part-time	33.3 (19)
Casual	7.0 (4)
<b>Profession</b>	
Registered Nurse	45.6 (26)
Physicians	22.8 (13)
Healthcare Aide	7.0 (4)
Spiritual Care Specialist	5.2 (3)
Unit Clerk	3.5 (2)
Occupational Therapist	3.5 (2)
Licensed Practical Nurse	3.5 (2)
Housekeeper	1.7 (1)
Social Worker	1.7 (1)
Psychologist	1.7 (1)
Respiratory Therapist	1.7 (1)
Physiotherapist	1.7 (1)
<b>Care Setting**</b>	
Home Care	29.8 (17)
Hospice	26.3 (15)
Hospital Dedicated Palliative Care Unit	21.0 (12)
Hospital Palliative Care Consult Service	14.0 (8)
Palliative Care Administrator	7.0 (4)
Outpatient Oncology Palliative Care Consult Service	5.2 (3)
Rural Palliative Care Consult Service	5.2 (3)
Other	1.7 (1)
<b>Religious Affiliation*</b>	
Christian	52.6 (30)
Buddhist	7.0 (4)
Jewish	3.5 (2)
Muslim	1.7 (1)
Hindu	1.7 (1)
None	31.5 (18)
<b>Religious and Spiritual Status*</b>	
Spiritual and Religious	33.3 (19)
Spiritual but not Religious	56.1 (32)
None	8.7 (5)

\* The total for these categories is less than 100% due to non-responses by participants

\*\*The total for these categories is more than 100% due to some participants working in multiple care settings

## Data collection

Data were collected via an interview guide (Tables 2-4) using focus groups and one-on-one semi-structured interviews across three study stages. In the first stage, 35 frontline HCPs participated in one of 7 focus groups, ranging from 1-1.5 hours in duration. Meetings were held in a private conference room at their place of work. The purpose of the focus groups was to obtain an understanding of the perspective of a broad cohort of interdisciplinary care providers involved in direct patient care. The second stage involved interviews with HCPs who were nominated by their peers as exemplary compassionate healthcare providers in order to elicit an advanced understanding of the qualities, skills knowledge and behaviours associated with compassion from the perspective of clinical experts. Exemplary compassionate care providers were nominated by focus group participants, via a question within the study demographic questionnaire that asked them to nominate up to two of their interdisciplinary peers whom they considered to be exemplary compassionate healthcare providers. A total of 15 individual interviews were conducted in a private room at their place of work, with 3 of these individuals having also participated in Stage 1 focus groups. The final stage of data collection occurred through two focus groups with Stage 1 and 2 study participants (n=5) and key stakeholders (n=10) (administrators, clinical leads and health faculty educators) in order to assess the validity of the model and facilitate knowledge translation and future research directions. Stage 3 focus groups were also used to further fulfill the criteria for rigor in qualitative studies: fit (categories should emerge from the data and not the pre-existing theoretical perspective of the researchers); work (the ability for the theory to explain and interpret behaviour in the area of study); relevance (the theory is relevant to clinical care); and modifiability (that the theory is adaptable to different contexts and as new data becomes available).<sup>41</sup> All focus groups and interviews were conducted

by an experienced qualitative interviewer who was not a member of the analysis team, with the exception of the first two focus groups in Stages 1 and 3, which were conducted by the Principal Investigator (SS) for training and standardization purposes. The interviewer was neither a member of the clinical team and had no previous relationship with study participants. In addition to a formal orientation and protocol training session in accordance with Straussian grounded theory, we mitigated against interviewer bias by utilizing a standardized interview guide and instructing the interviewer to focus on active listening, participant responses and predetermined prompting questions (Table 2). The focus groups and interviews were audio-recorded and transcribed verbatim, with contextual content (such as emotions and non-verbal communication) being recorded in the form of field notes. The verbatim transcripts were independently verified against the audio recording by the interviewer and a member of the analysis team (SS). The fidelity of each focus group and interview session was further ensured by having the analysis team analyze the interviewer's adherence to the protocol and the performance of the interview questions in each transcript, and providing feedback and correction.

**Table 2: Stage 1 Focus Group Guiding Questions**

1. Based on your professional and personal experience, what does compassion mean to you?
2. Can you give me an example of when you felt you provided or witnessed care that was compassionate? [What do you feel were the key aspects of these interactions?]
3. What do you feel are the major influencers of compassionate care in your practice?
4. What do you feel inhibits your ability to provide compassionate care?
5. Do you think patients and/or family members influence the provision of compassionate care? [How or how not?], [If yes, what characteristics of patients and/or families, do you feel facilitate or inhibit compassionate care?]
6. What advice would you give other healthcare providers on providing compassionate care?



7. Do you think we can train people to be compassionate? [If so, how]?
8. Based on your experience what role, if any, do you feel compassion has in alleviating end of life distress? [What happens when compassionate care is lacking?]
9. What impact does providing compassionate care have on you personally and professionally?
10. Is there anything related to compassion that we have not talked about today that you think is important or were hoping to talk about?

**Table 3: Stage 2 Interview Guiding Questions**

1. You have been identified by your peers as possessing great skill in providing compassionate care. What do you feel might be some of the reasons for this recognition? [Why do you think others identify you as a compassionate healthcare provider?]
2. In your own terms, how would you define compassion? [What does compassion mean to you?]
3. How did you become a compassionate caregiver? [What beliefs, situations, individuals and/or life experiences in your life and practice do you feel have informed your understanding and provision of compassionate care? Have you always been that way? [Were you always like that? How did you learn it? Can it be learned?]
4. If you reflect back on your current position, can you walk me through the best example of when you provided compassionate care? [What constitutes compassionate care in an admin/phone triage role? Please guide me through the process of this encounter in a sequential fashion, highlighting the key components of this interaction from the initial approach to the consequences of this interaction?]
5. Based on your professional and personal experiences, what shapes your compassionate care?
6. If you were responsible for training students in compassionate care, how would you go about it? [What would you teach them?]
7. Is there anything that gets in the way of your ability to provide compassionate care?
8. How do patients and/or families influence how your ability to provide compassionate care? [What characteristics of patients and/or families, do you feel facilitate or inhibit compassionate care?]

9. A number of participants have identified the healthcare system as being a significant factor in delivering compassionate care? From your perspective, how does/can the healthcare system facilitate or inhibit compassionate care?
10. In light of the things you've just identified as facilitators and barriers, what suggestions would you have for enhancing compassion at a systems level? [Where and what would you focus your efforts on in order to enhance compassion at a systems level]?
11. From what you've told me so far, it sounds like compassionate care is important. So what happens [to patients, families or HCPs] when compassionate care is lacking?
12. What impact does providing compassionate care have on you personally and professionally?
13. Our focus group participants, previous studies and review of the literature have reported how critical and fundamental compassion is to providing quality patient care, but we also know that compassionate care varies. So given all that we know about the importance of compassionate care, why aren't healthcare providers more compassionate?
14. Before we end, given all we've talked about, I just want to revisit one of the first questions I asked, which is how do you personally define compassion? [In light of our discussion, what does compassion mean to you?]
15. Is there anything related to compassion that we have not talked about today that you think is important or were hoping to talk about?

**Table 4: Stage 3 Focus Group Questions**

1. Does the healthcare provider model of compassion make sense to you? [Does it resonate with you]? [Why or Why not]?
2. Do you feel there is anything missing from the model?
3. How do you feel this model might be relevant to you and your work?
4. How do you suggest the model might be integrated into healthcare practice and education?
5. Is there anything related to the model that we have not talked about today that you think is important or were hoping to talk about?

## Data Analysis

This study was guided by Straussian grounded theory, an inductive, iterative, qualitative method that aims to define and construct a theoretical account of a topic grounded in study data within a naturalistic setting.<sup>38 41 42</sup> Grounded theory is particularly useful method when investigating social processes related to a complex phenomena that are based in the subjective experience of participants.<sup>41 42</sup> Five members of the research team, who have extensive research and teaching experience in qualitative methods (SS, TH, SM, SRB, KS) analyzed the data in accordance with the three stages of analysis. The analysis team was comprised of two males and three females and professionally consisted of three nurses, a psychologist and a spiritual care provider. The first stage, open coding, involved each individual independently analyzing each transcript in a line-by-line manner. Individual codes were recorded in the margin, with subsequent codes being compared and contrasted with previous codes—an analytical process known as the constant comparative technique.<sup>38</sup> After independently analyzing each set of 2-3 transcripts, the analysis team (SS, TH, SM, SRB, KS) met to compare their individual codes. They read through each transcript again in a line-by-line fashion, settling differences between individual's codes and delineating incidences in the transcript that were non-specific to compassion through a process of consensus. This produced a 'master' coded transcript for each interview and focus group. Rigour was further assured by having three physician members (AS, NH, HMC) of the study team, who were not involved in analyzing the interviews or focus groups, independently audit the coding process. Axial coding, the second stage of analysis, began at a 3-day face-to-face analysis team meeting after Stage 1 focus group data had been analyzed. The purpose of axial coding is to compare codes with other data, to combine and

1  
2  
3 collapse codes, and to cluster codes into categories and themes. Axial coding generated a coding  
4  
5 schema which was used and modified in subsequent interviews. The third stage of analysis,  
6  
7 selective coding involved integrating and refining categories and themes after the theory and  
8  
9 core variable was identified, delimiting coding to those categories that relate to the core variable.  
10  
11 The theoretical model was finalized at a subsequent 3-day meeting and then vetted through the  
12  
13 study participant and a key stakeholder focus groups. This study met the 32 consolidated criteria  
14  
15 for reporting qualitative research (COREQ).<sup>43</sup>  
16  
17  
18

## 19 RESULTS

20  
21 Five categories and thirteen associated themes emerged from the data (Figure 1). The  
22  
23 core variable, which describes phenomenon of interest and links the categories together, is: *a*  
24  
25 *virtuous, intentional response to know and understand a person and ameliorate their suffering.*  
26  
27 The key dimensions of compassionate care are illustrated in a theoretical model (Figure 2),  
28  
29 which generated a HCP definition of compassion: *A virtuous and intentional response to know a*  
30  
31 *person, to discern their needs, and ameliorate their suffering, through relational understanding*  
32  
33 *and action.*  
34  
35  
36

37 \* **Figure 1. Elements of Compassion: Categories and Themes** (Please insert here)

38  
39 \* **Figure 2. Healthcare Provider Compassion Model** (Please insert here)

### 40 41 42 43 **Virtuous Intent**

44  
45 Participants provided insight into the innate qualities which served as the catalyst that  
46  
47 compassion flowed from and through. Compassion was not simply understood as an affective  
48  
49 response, but a response based in the virtues that participants brought into the clinical encounter.  
50  
51 The category of Virtuous Intent, *the purposeful desire to embody and express one's good and*  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 *noble qualities in professional practice*, was described by several participants as an internal  
4  
5 process of self/provider congruence.  
6

#### 7 8 Virtues: Personal Qualities 9

10 Study participants identified virtues as the primary motivator of compassion. While a few  
11  
12 participants identified virtues as a collective whole, most participants listed individual virtues  
13  
14 such as love, kindness, genuineness, care and peace which naturally distilled into this theme in  
15  
16 an iterative manner. Virtues were conceptualized as *the good character or noble qualities*  
17  
18 *embodied within HCPs that stimulated compassion*. In this study, virtues were not equated with  
19  
20 morality, religion, or spirituality, although some participants did identify these as potential  
21  
22 facilitators; rather, they were human qualities that could be developed through a variety of other  
23  
24 means including family upbringing, role modelling, self-reflection, and life experience. As a  
25  
26 result, while participants felt that every HCP possessed and could cultivate virtues, they  
27  
28 acknowledged variation in these innate qualities based on personal and professional experiences,  
29  
30 willingness, and circumstance. While compassion was conceptualized as a multi-dimensional  
31  
32 construct (Figure 2), the other categories of the model had to flow through virtues of love,  
33  
34 acceptance, honesty, genuineness, humility and kindness to be considered compassionate.  
35  
36 Compassion's rootedness in HCPs virtues was viewed by participants as a distinguishing feature  
37  
38 of compassion in comparison to other expressions of care (e.g. routine care, empathy, sympathy).  
39  
40  
41  
42  
43

44 Genuine love for your fellow man, that helps you be compassionate and to want to care  
45 for people (Interview Participant 3).  
46

47  
48 When I think of empathy and I think of compassion, I think that compassion is a bit  
49 broader and deeper and more loving (Interview Participant 15).  
50

51 I think you can say the right words, but I think there has to be genuineness behind it.  
52 And I think people pick up on that whether you're acting or not (Interview Participant 7).  
53  
54

#### 55 Presence: Embodied Virtues 56 57 58 59 60

1  
2  
3 Presence was understood as *the distillation and expression of personal virtues to others*  
4 *through the character of an individual*. In other words, according to participants, virtues in  
5  
6 relation to compassion, were not considered static traits, but needed to permeate through the  
7  
8 presence of HCPs into their practice. Since HCPs felt that patients could intuitively sense their  
9  
10 virtues and capacity for compassion, they emphasized the importance of self-awareness and  
11  
12 developing these inner qualities prior to interacting with the patient.  
13  
14  
15

16  
17 There's something in the caregiver that resides in the caregiver but it's sort of, there's this  
18 catalytic thing that happens when it comes into the presence of someone else's suffering  
19 and then something could catch fire or not (Stage 1 Focus Group Participant 12)  
20

21  
22 Being genuine, they can see that and they can feel that so... it's almost like an energy that  
23 occurs as well. They can feel it and you can feel it... I always say can I be vulnerable in  
24 their presence and try to equalize it and I don't necessarily disclose my human spirit but I  
25 think I release it in a way that allows them to bring it forward (Stage 1 Focus Group  
26 Participant 23).  
27

28  
29 Before we ever say a word, people feel from us who we are, in these beds and in these  
30 rooms. And that's compassion (Interview Participant 6).  
31

### 32 Intention: Embodied Presence 33

34  
35 Immediately prior to engaging with the person in suffering, many participants described  
36  
37 an intentional practice, whereby they adopted *a self-effacing and curious attitude toward the*  
38  
39 *patient and tried to orientate themselves to the patient's perspective*. In several participants, the  
40  
41 necessity for a self-effacing attitude to compassionate care was explicitly described. In contrast,  
42  
43 it was implicit in the responses of many of the exemplary compassionate caregivers, whom upon  
44  
45 being notified that they had been nominated, spontaneously indicated that they did not self-  
46  
47 identify as being particularly compassionate. This intentional process of concurrently demoting  
48  
49 oneself and trying to take the perspective of the patient, reflected participants' belief that  
50  
51 compassion involves forethought and choice. Compassion was described as being conveyed  
52  
53 through the virtues or energy that HCPs conveyed in interacting with a patient. Participants,  
54  
55  
56  
57  
58  
59

1  
2  
3 however, were clear that this didn't occur through happenstance, but through a process of self-  
4 reflection whereby HCPs drew awareness to their internal state and intentionally tried to put  
5  
6 aside their own frustrations, needs, wishes and preconceptions about the patient in order to  
7  
8  
9  
10 practice compassion.

11  
12 Everyone has the possibility to be compassionate. They just have to choose to be  
13 (Interview Participant 1).  
14

15  
16 It's almost like a different intentional way of being that you have to work on or cultivate  
17 (Stage 3 Focus Group Participant 1).  
18

19 I think compassion is about coming with an open, maybe even curious attitude of being  
20 able to be present with another individual... So being able to suspend what's going on for  
21 those few moments when you enter and so, you know it's kind of like you know  
22 envisioning as you approach the door and taking that deep breath and kind of cleansing  
23 yourself to walk into that room (Interview Participant 8).  
24  
25  
26

## 27 **Relational Space**

28  
29 Participants situated the core categories of compassionate care within a broader relational  
30 space, which was defined as *the context for compassion where the virtuous intent of the*  
31 *caregiver engages the suffering of a person.* Relational space differed from other categories in  
32 that it was not a mutually exclusive category, as the three categories 'Coming to Know the  
33 Person'; 'Forging a Healing Alliance' and 'Ameliorating Suffering' were nested within it. This  
34 was due to participants' belief that compassion was embedded in a relational approach that  
35 traversed the three categories subsumed within it. Compassion was relational in that it was  
36 regulated by an openness by patients to receive compassion and a willingness on the part of the  
37 HCP to be professionally and personally impacted by the suffering of their patients.  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49

50  
51 Compassion involves two people or more I guess, but it's not just sort of one person I am  
52 being---I am exuding compassion. Like I think it needs to be given and received and I  
53 see it as kind of going back and forth. (Interview Participant 8)  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 It's not something that exists just within me. It's something that occurs between me and  
4 somebody else. (Interview Participant 1)  
5

### 6 **Coming to Know the Person**

7  
8  
9 Having established an initial connection to their patient within the relational space HCPs  
10 described an ongoing process of coming to know the person, *an attentive and sensitive approach*  
11 *that seeks to engage, see, accept, and understand the patient as a person.*  
12  
13

### 14 **Engaging the Patient in a Sensitive Manner**

15  
16  
17 HCPs described the importance of engaging the patient in an attentive and sensitive  
18 manner within the clinical encounter. This involved HCPs *attuning to the energy of the room, the*  
19 *patient's presence, and interpersonal cues in order to be attentive to the person and to develop*  
20 *an awareness of their background.* Many participants felt that this approach allowed them to  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
develop an appreciation of the patient's broader life story, to see the patient as a person, and  
accept them where they were at.

This is the sensitive part you're matching their energy level for that time that they're in  
the hospice or that time you're in that room (Interview Participant 12).

Sensitivity would probably be one of the---being able to read a room when you walk into  
it and kind of know what's going on or sense what's going on there and be sensitive to  
the dynamics that you feel between people there (Interview Participant 1).

### 61 **Seeing the Patient as a Person**

62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100  
In the context of clinical care, participants were emphatic about the importance of  
*extending one's vision beyond the illness, the body, and 'the patient' in order to view the person*  
*as a fellow human.* Seeing the patient as a person ranged from simple gestures such as asking the  
person how they preferred to be addressed, to eliciting the person's story, to allowing the person  
to make care decisions versus telling them what to do.

I think what we need to do is we need to see this person as a human being... treat this  
person as a human being and not as the patient with diagnosis X, but as a person who has



1  
2  
3 had all of these lived experiences that is at this place and is feeling this way (Interview  
4 Participant 8).  
5

6  
7 So, you need to look them in the eyes and be soft and kind and like 'I see you behind  
8 there'. And I'm going to take care of you, like I've got you, like I got this (Interview  
9 Participant 15).  
10

11 I think true compassion is you know an understanding individually of what is it that  
12 person wants and needs from us that we can give to them? (Interview Participant 2).  
13

#### 14 Accepting The Person Where They Are At 15

16  
17 Participants described a third theme that involved *seeking to understand the person's*  
18  
19 *circumstance and accept them unconditionally in spite of their past and/or present behaviours.*  
20

21 This primarily involved accepting patient attitudes, behaviours, and frustrations that were related  
22  
23 to their situation. Extending unconditional acceptance toward abusive patients or individuals  
24  
25 with a checkered past served as both the greatest challenges to compassion and case exemplars  
26  
27 of their compassionate colleagues.  
28  
29

30  
31 One of the nursing attendants told me one day how he had been with a patient for two  
32 days and this guy had been incontinent of stool and just messed himself again and he was  
33 unsteady and the nursing attendant was supporting the guy and cleaning him up and while  
34 he was back there cleaning the back of his legs his bowels let go again and this  
35 professional, without complaint, began to wash the guy again. And the man turned  
36 around and using a racial epithet cursed him, what are you doing back there you fuck, and  
37 again the man took it with humility and generosity of spirit and didn't strike back with  
38 words or actions but fulfilled his duty. That's a striking story of compassion (Stage 1  
39 Focus Group Participant 4).  
40  
41

42 We've had a holocaust survivor. We've had a German soldier you know, who was  
43 forced into doing things that they didn't want to do.... We have to have compassion all  
44 around for each person (Interview Participant 2).  
45  
46

47 One example that comes to mind is a young woman, who was a prostitute...and I was  
48 working in the OR and people were talking over her in a very disparaging manner...and I  
49 remember my thought at the time was I don't think she thought as a little girl 'Gee, I'd  
50 like to be a prostitute when I grow up'. But stuff happened in her life that that's where  
51 she was (Stage 3 Focus Group Participant 3).  
52  
53

#### 54 **Forging a Healing Alliance** 55 56 57 58 59 60

1  
2  
3 Although participants felt that compassion did not require a pre-existing relationship,  
4 they nonetheless felt that compassion was further forged and optimized through the  
5 establishment of a therapeutic relationship-- *a relationship that is nurtured that is cultivated*  
6 *through verbal and non-verbal communication that promotes healing through an in-depth*  
7 *understanding of the person and their unique experiences in order to personalize compassionate*  
8 *care.* Four interrelated themes comprised the category of Forging a Healing Alliance: being  
9 present; relational communication; therapeutic relationship; and in-depth understanding of the  
10 person.  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20

#### 21 Being Present: Demeanor

22  
23 While time was a factor in forging a healing alliance, participants also felt that it could be  
24 quickly established through the demeanor HCPs conveyed within each clinical encounter  
25 regardless of its duration. According to several participants, demeanor involved attempting to be  
26 fully present to the patient and was reflected in the way in which care is given—whereby their  
27 demeanor enriched each care interaction.  
28  
29  
30  
31  
32  
33

34  
35 Because it's not what you do, it's the way you do things for people that is compassion  
36 (Stage 1 Focus Group Participant 35).

37  
38 She's [exemplary compassionate care nominee] fully present in every room and when  
39 caring for someone, she makes it seem like they're the only person she has to take care of  
40 (Stage 1 Focus Group Participant 24).

41  
42 He [nominee] provides comfort with his calm and gentle demeanor (Stage 1 Focus Group  
43 Participant 15).

#### 44 Relational Communication

45  
46  
47 Relational communication was described as *the establishment of a deeper understanding*  
48 *of the person and their individualized needs through active listening.* The centrality of listening  
49 relative to compassion involved listening to what patients said, but also listening to the subtext of  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59

1  
2  
3 what wasn't being said— tone of voice, moments of silence, and non-verbal cues that helped to  
4  
5 unmask hidden suffering.  
6

7  
8 I think when people feel heard and they feel like someone actually cares and actually is  
9 taking the time to listen that's what they interpret as being compassionate (Interview  
10 Participant 7).  
11

12 When they call I usually just drop everything and you listen to their tone of voice. I can  
13 hear it when the tears are there you know... there's that pause and I let that pause happen  
14 because they're deciding whether or not they're going to tell me or they're realizing how  
15 overwhelmed they really are (Interview Participant 13).  
16  
17

18 It's listening to what's not being said and recognizing that and really gently making it  
19 okay to talk about those things (Interview Participant 15).  
20

## 21 Therapeutic Relationship

22  
23 The themes of being present and relational communication were instrumental in  
24 establishing a deeper therapeutic relationship which participants described as *a human-to-human*  
25  
26 *connection facilitated through the mutual sharing of stories, feelings, and expressions of care*  
27  
28 *between healthcare providers and their patients in order to promote healing.* Establishing a  
29  
30 therapeutic relationship extended the largely unidirectional theme of 'Seeing the Patient as a  
31  
32 Person' to a reciprocal level, whereby participants related to their patients from a place of shared  
33  
34 humanity.  
35  
36  
37  
38  
39

40 He [physician nominee] tries to find out who they are and makes time for social visits not  
41 just medical assessments (Stage 1 Focus Group Participant 29).  
42

43 I really wanted to understand, but not from a head space, like from a heart space in terms  
44 of the feeling and really kind of connecting that way with her (Interview Participant 15).  
45  
46

47 I try to have a sense of what story they're living and be able to kind of feel how I can be a  
48 constructive player in that story (Interview Participant 1).  
49  
50

## 51 In-Depth Understanding of the Person

52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 The end outcome within the category of forging a healing alliance was to come to an in-  
4 depth understanding of the person, allowing HCPs to address a person's multifactorial needs in a  
5 personalized manner. Coming to an in-depth understanding of the person was conceptualized as  
6 *a deep desire to engross oneself in a person's story in order to determine sources of personal*  
7 *meaning and how these were effected by and contributed to their suffering.* Whereas the theme of  
8 'Intention' involved emotional resonance (feeling with), in which participants considered how  
9 they would want to be treated if they were in the patient's position, an in-depth understanding  
10 engaged a higher process of 'feeling for' the patient. This involved moving beyond considering  
11 how the HCP would want to be treated if they were the patient, to in having developed an in-  
12 depth understanding of the person--an understanding of how the patient would want to be  
13 treated.  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27

28 The Golden Rule is good to a point, but sometimes somebody else might not want what I  
29 want (Interview Participant 15).

30  
31 What brings meaning to them and it's about how we engage and being able to support  
32 that (Stage 1 Focus Group Participant 30).  
33  
34

### 35 **Ameliorating Suffering**

36  
37 The primacy of action within each of the categories of compassion culminated in  
38 participants identifying 'ameliorating suffering' as the ultimate goal of compassion.  
39

40 Ameliorating suffering was defined as *tangible acts intended to alleviate actual or anticipatory*  
41 *threats to a person's physical, emotional, social and/or spiritual wellbeing.*  
42  
43  
44

### 45 **Discerning Needs**

46  
47 The Theme of Discerning Needs describes *the ability to anticipate, perceive or prioritize*  
48 *health care needs based on knowledge of the person and their circumstance in order to alleviate*  
49 *their suffering.* Discernment ranged from anticipating an impending pain crisis, to recognizing  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 the patient's need for personal space, preparing the patient for a prognostic conversation,  
4  
5 demoting competing system priorities, and prioritizing which patients needed compassion the  
6  
7  
8 most.

9  
10 One of the strategies that I usually employ is I try to think about at the beginning of the  
11 day, you know who needs the most time today? And then structure my day accordingly  
12 as much as possible... (Interview Participant 9).

13  
14 The discerning needs piece really resonated with me, thinking back to my days as a  
15 bedside palliative care nurse...it's absolutely true, especially discerning which patients  
16 need more compassion (Stage 3 Focus Group Participant 5).

17  
18  
19 Then that's where anticipatory care is really important, because you're like I've already  
20 thought of that. That's why I just gave him a break-through because he's looking like he  
21 was in pain and he has to go to radiation in half an hour, so follow along (Interview  
22 Participant 4).

#### 23 24 25 Providing Emotional and Existential Support

26  
27 While compassion traversed the care trajectory, health domains and the caregiver/patient  
28 relationship, participants also identified key moments where compassion seemed to be essential  
29 or most needed--incidences of suffering that included emotional and existential distress.

30  
31  
32 Providing emotional and existential support involved *allaying uncertainty, fears, and distress*  
33  
34 *that threaten personal existence by eliciting meaningful memories, affirming strengths, and*  
35  
36 *providing supportive touch and words of affirmation.*

37  
38  
39 To me it didn't seem humane that this gentleman was gonna die alone, it just didn't seem  
40 right that he'd had no visitors and now he was gonna leave this world alone. I don't know  
41 if he knew I was there but I just held his hand and talked softly (Stage 1 Focus Group  
42 Participant 3).

43  
44  
45 I'm doing what I'm setting out to do and it's not only my job physically, but it's that  
46 bigger---maybe kind of total... but then there's a psychosocial, spiritual pain that they  
47 can be having (Interview Participant 11).

48  
49  
50 I think that we can have all the words and have all the nice clothes and look like we've  
51 very efficient, but I think it's compassion that shakes the hand of another person and that  
52 rubs their forehead, that opens the door to their heart where they feel safe (Interview  
53 Participant 6).

## Addressing Needs

The final theme, addressing needs, involved *a proactive and attuned response to directly engage in and alleviate a person's multifactorial suffering*. Participants expressed that compassion addressed needs primarily in two ways: small acts of compassion within HCPs' call of duty; and extraordinary acts beyond the call of duty. There were several specific examples of small acts of compassion identified. They included exercising diligence and sensitivity in routine care such as attending to activities of daily living; and demonstrating attention to detail in seemingly perfunctory activities such as filling out a patient's paperwork or conveying patient preferences at shift change. Addressing needs that fell outside of the call of duty or 'going the extra mile' were arguably the greatest indicators of a compassionate HCP and were the most frequently stated reason for peers to nominate their exemplary colleagues. In many ways, these extraordinary acts seemed to function as a litmus test to detect whether care was internally motivated from a place of virtues or an ulterior motivator such as remuneration, duty, or social desirability.

I think that empathy is really understanding the feeling and perspective kind of or what is happening for that person. I think the compassion is taking that and translating it into an actionable item (Interview Participant 15).

And the little things too, when people are in bed we ask them if they like ice water or room temperature water and it seems like a pretty minor thing but if you don't really like ice water and you have a jug of it at your bedside and that's all you have to drink that's not really compassion (Stage 1 Focus Group Participant 8).

It's making sure that their paperwork is done and their paperwork is sent out and following up on things that maybe got dropped along the way... There's compassion in that too, because you want to make sure that the road is paved as smoothly for that family and that patient as possible (Interview Participant 13).

They stop at the cafe to get a bowl of soup that they know that that patient likes that bowl of soup. It has nothing to do with their job but they know that they're not eating and if

1  
2  
3 they hear them say something that they like, they stop and pick it up...and they sit and  
4 eat with them (Stage 1 Focus Group Participant 29).  
5  
6  
7

## 8 **DISCUSSION**

9

10 Compassion is widely regarded as an essential part of quality healthcare. In contrast, the  
11 construct is still at an early stage of research development, with limited clinical studies  
12 describing how aspects of compassion can be operationalized in practice. The HCP Compassion  
13 Model delineates the key dimensions of this dynamic construct and begins to address this theory-  
14 practice gap. We hope it will foster discussion as a pragmatic tool for evidence informed practice  
15 and as an empirical foundation for future studies in this area.  
16  
17  
18  
19  
20  
21  
22  
23

24 This study conceptualized compassion within healthcare from the perspective of HCPs,  
25 extending our previous research on patients' perspectives<sup>19</sup>. While we had anticipated that the  
26 HCP Compassion Model would be depicted in a distinct fashion to the Patient Compassion  
27 Model,<sup>19</sup> our analysis revealed that while there were some differences at a thematic level, the  
28 core categories largely mirror the Patient Compassion Model—illustrating the flipside of the  
29 compassion dyad (Figure 2). This was further verified by Stage 3 participants, who provided  
30 face validity as they endorsed the structure and temporal flow of the model. The model parallels  
31 the sequential clinical process of a HCP approaching the bedside, making an initial relational  
32 connection, getting to know the person, forging a therapeutic alliance, and then working to  
33 ameliorate suffering. While the model depicts a sequential flow of compassion between and  
34 within categories, Stage 3 participants cautioned against a strict stepwise conceptualization of  
35 compassion, noting that in reality there was oscillation across the model. In practice, this  
36 suggests that HCPs can revisit earlier themes within the model. For example, they likely reassess  
37 their intentions on an ongoing basis at each clinical interaction or come to a deeper acceptance of  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 the person as the therapeutic relationship is strengthened. Likewise, while participants felt that  
4 each of the categories needed to be engaged for care to be considered compassionate, the three  
5 intertwined categories within the model's core illustrate that certain dimensions of compassion  
6 may be more prominent to others, while still reaching the same ultimate outcome--addressing a  
7 person's needs. For example coming to know a person may be more prominent in admitting a  
8 stable patient to a care home, whereas ameliorating suffering will likely be more prominent when  
9 treating a patient with an acute pain crisis. These 5 dimensions depicted within the model are  
10 congruent with previous research which identified compassion as a multi-dimensional construct  
11 consisting of clinical behaviours, communication skills, presence, understanding and emotional  
12 engagement.<sup>13</sup> The current study extends this previous research by providing greater detail about  
13 the contents of these dimensions through the 13 themes contained within them, while also adding  
14 the Virtuous Intent dimension, identifying the pivotal role that virtues play in engendering a  
15 compassionate response within HCPs.  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32

33 A multidimensional understanding of compassion adds depth to current constructs of  
34 compassion both at the bedside and in research. Much of the previous work has focused on  
35 unidimensional conceptualizations of compassion limiting it to a feeling, a trait, or a virtue,  
36 producing corollary interventions to improve HCP affective components of compassion through  
37 contemplative practices and mindfulness training.<sup>9 44-46</sup> Inarguably, interventions aimed at  
38 enhancing awareness of HCP attitudes and cultivating virtues of love, kindness, altruism, and  
39 equanimity, are essential to improve compassionate care. The current work offers the opportunity  
40 to augment these with training focused on clinical skills and behaviours reflecting the  
41 interdependent categories and themes on which compassionate care is grounded.  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 HCP participants provided insight into the internalized processes of compassion, which  
4 patients in our previous study could only postulate due to their limited perspective as the  
5 recipients of compassionate care. At a categorical level these new findings resulted in the  
6 emergence of the broader category of ‘Forging a Healing Alliance’, with ‘Relational  
7 Communication’ being subsumed as a theme within it. The additional theme of ‘Therapeutic  
8 Relationship’, along with the themes Demeanor and Relational Communication, emphasize  
9 HCPs’ intent and the centrality of coming to an in-depth understanding of the patient as a person  
10 in compassion, affirming similar research in the field of psychology.<sup>20 47</sup>

11  
12 A more fulsome understanding of compassion at a thematic level emerged from this  
13 study, as according to HCPs, compassion was not a systemic form of caring, but an intentional,  
14 discerning and targeted modality. This affirms other researchers’ work on the topic, who  
15 reported that compassion is not coincidental but involves choice<sup>12 13 48 49</sup> and the down-regulation  
16 of destructive HCP thoughts and behaviours.<sup>50</sup> Considering this prior and current research, we  
17 suggest that compassion may be conceptualized through the lens of ‘personalized healthcare’,  
18 extending the concept of personalized medicine that focuses on tailoring the treatment of disease  
19 based on individual characteristics,<sup>51</sup> to each interaction the patient has with their HCPs.

20  
21 The themes of ‘Discerning needs’ and ‘Intention’ raise additional questions regarding the  
22 unconditional nature of compassion. Previous research identified compassion as largely being an  
23 unconditional care construct, in comparison to the conditional nature of sympathy, which is  
24 mediated by the self-preservation of the caregiver, and empathy, which is effected by perceived  
25 relatedness and deservedness.<sup>39 52 53</sup> According to HCPs, compassion involved bringing an open  
26 mind and not simply an empty head to each patient encounter,<sup>31 54</sup> echoing Wilber’s summation  
27 that, “real compassion includes wisdom and so it makes judgments of care and concern”.<sup>55</sup>

1  
2  
3 Results from the current study suggest that reasoning, as it relates to compassion, assesses  
4 individuals' needs and seeks to understand the person, in contrast to other care constructs that  
5 seem to focus more on assessing the individual and allowing this to determine how to act  
6 accordingly. In a similar vein, participants' identification that compassion involved choice, is  
7 further evidence that while compassion involves cognitive processing, it is not selective. Rather,  
8 the practice of intentionality involved exposing and counteracting these subconscious conditions  
9 and barriers in order to accept the person in an unconditional manner—expanding ones' capacity  
10 for compassion in the process.  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20

21 One of the surprising findings of this study was the identification of virtues, the good and  
22 noble qualities embedded within the character of HCPs, as the primary motivator of  
23 compassion—unexpectedly replicating the results of our patient study.<sup>19</sup> Several HCPs went so  
24 far as to describe compassion as a process of self/provider congruence, whereby they attempted  
25 to integrate and cultivate their virtues into their professional practice.<sup>56</sup> Leaders in healthcare  
26 practice, policy and education might appropriately ask, can compassion be mandated, learned  
27 and evaluated at the bedside? The current study suggests that this remains a challenging and  
28 controversial proposition as genuine compassion involves the personal qualities of HCP and  
29 extraordinary acts that go beyond standard practice, job expectations or routine care. While  
30 making healthcare more compassionate is a pressing need, doing so by requiring HCPs to act in a  
31 way that is perceived by patients as compassionate is not only disingenuous and antithetical to  
32 compassion, but leads to a standardized approach that denudes HCPs of personal expression and  
33 the opportunity to demonstrate care beyond what is expected.<sup>2 3 6-8</sup>  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50

## 51 **Strengths and Limitations**

52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 This study has several strengths and limitations. Prior work in this field has broadly  
4 considered physician, patient and family, clinical situation, and environmental factors which  
5 individually and transactionally contribute to compassion.<sup>14 15</sup> The current study seeks to expand  
6 on this work, by delineating elements which are at the root of these factors, across a range of  
7 training backgrounds of physicians, other health care providers, and support staff involved in the  
8 delivery of healthcare. This study also assesses the interdependence of these elements building  
9 on research describing dimensions of compassion based on the direct reports of nurses caring for  
10 older people with a chronic disease.<sup>12 13</sup> The current study adds to this knowledge base in its  
11 interdisciplinary focus, inclusion of urban and rural populations, recruiting from multiple types  
12 of care settings, and the identification of the virtuous intent dimension, demonstrating that  
13 compassionate communication and action is informed and regulated by certain HCP qualities.  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27

28 We recruited participants from a palliative care program in order to study compassion.  
29 We recognize that while compassion is deemed an essential element of healthcare, and is central  
30 to the professional motivation of the majority of healthcare providers, it is inarguably of great  
31 relevance in a healthcare environment which provides care where suffering is prevalent. We  
32 reasoned that while team members in a Palliative Care setting do not have a monopoly on  
33 compassion, they share with other healthcare providers across other healthcare settings, a deep  
34 professional respect for its relevance and importance.  
35  
36  
37  
38  
39  
40  
41  
42  
43

44 This begs the question--Are the findings from this study generalizable to other healthcare  
45 settings? Palliative care is by nature a team based environment, and each professional group  
46 within it contributes to the overall culture of care. Dissecting out the perspectives of specific  
47 healthcare professional groups within the team as being distinct from the team itself may  
48 ultimately be identified as a worthwhile approach to better understanding barriers and facilitators  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 to compassion, but at present requires further research. It is known that physician barriers to  
4  
5 compassion are different based on number of years of clinical experience and different medical  
6  
7 specialties.<sup>14 15</sup> We therefore reasoned that it was wise to first establish what is common,  
8  
9 establishing the empirical foundation of the construct, allowing future studies to further validate  
10  
11 its generalizability and transferability to other settings and specialties..  
12  
13

14  
15 Further, while the snowball sampling technique of Stage 1 participants nominating Stage  
16  
17 2 interviewees was beneficial, it may have diminished the heterogeneity of the sample, as  
18  
19 participants may have inadvertently nominated like-minded individuals. Similarly, the HCPs  
20  
21 sampled in this study were predominately nurses and physicians. While reflecting the  
22  
23 composition of an interdisciplinary team and being representative of the professional  
24  
25 composition of healthcare as whole, it may not adequately represent the views of other groups of  
26  
27 professionals. Finally, while participants identified behaviours that were associated with  
28  
29 compassion, these were not verified by observational data.  
30  
31

### 32 33 **Implications for Research, Policy and Clinical Practice**

34  
35 The HCP Compassion Model provides a foundation that defines compassion in  
36  
37 healthcare and its provision at the bedside. It may lead to the development of clinical tools to  
38  
39 cultivate the requisite knowledge, skills, behaviours, and qualities to enhance compassionate care  
40  
41 to others. For example, it could potentially inform the development of a patient reported  
42  
43 compassion measure or serve as a blueprint to develop targeted and evidence informed  
44  
45 educational interventions for healthcare systems aiming to enhance patients experiences of  
46  
47 compassion specifically.<sup>17</sup>  
48  
49  
50

### 51 **Conclusions**

1  
2  
3 This study provides HCPs, educators, researchers and policy makers with a multi-  
4 dimensional model of compassion. It identifies the knowledge, skills, behaviours and qualities  
5 which underpin delivery of compassionate health care at the bedside. The systematic nature of  
6 the HCP Compassion Model characterizes the components of compassion and their  
7 interrelatedness. There is also an element of flexibility within these domains that recognizes that  
8 true compassion comes from within the person, through a dynamic human interaction with a  
9 patient and the patient's needs. While mastery may be unattainable, the multidimensional facets  
10 of compassion can potentially be nurtured in individual health care providers and throughout the  
11 cultures they work within.  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

### 26 **Disclosures and Acknowledgements**

27  
28 Contributors: All nine authors fulfill all four of the International Committee of Medical Journal  
29 Editors guidelines for authorship. SS, SRB, TH, SM, KS, AS, NH and HMC conceptualized the  
30 study. SS supervised PS who managed, acquired, cleaned and coordinated analysis of the data.  
31 SS, SRB, TH, SM, KS and PS analyzed interview and focus group data. All authors contributed  
32 to the final draft and approved the final version for publication.  
33  
34

35 Acknowledgements: We would like to acknowledge and thank the MSI foundation for funding  
36 this study. We would like to acknowledge Kate Beamer, research assistant, for her dedication  
37 and commitment to this study. We would also like to acknowledge and thank the research  
38 participants who generously shared their time, wisdom, experiences and enthusiasm on the topic.  
39

40 Data Sharing Statement: No additional data are available  
41

42 Funding Statement: This study was supported by a MSI Foundation Grant, (Grant #880).  
43  
44

45 Competing Interest Statement: The authors declare no conflicts of interest.  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

For peer review only

## References:

1. American Medical Association. Code of medical ethics 2006 [Available from: <https://www.ama-assn.org/about-us/code-medical-ethics> accessed 23 February 2017.
2. Department of Health. Confidence in caring: A framework for best practice. 2008 [Available from: [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086387?IdcService=GET\\_FILE&dID=144574&Rendition=Web](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086387?IdcService=GET_FILE&dID=144574&Rendition=Web) accessed August 4 2017.
3. Flocke SA, Miller WL, Crabtree BF. Relationships between physician practice style, patient satisfaction, and attributes of primary care. *J Fam Pract* 2002;51(10):835-40.
4. Paterson R. Can we mandate compassion? *Hastings Center Report*;41(2):20-3.
5. MacLean L. The Vale of Leven Hospital Inquiry Report 2014 [Available from: <http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf> accessed May 2 2017.
6. The Willis Commission. Quality with compassion: the future of nursing education. Report of the Willis Commission on Nursing Education 2012 [Available from: <https://www.nursingtimes.net/download?ac=1255026> accessed May 2 2017.
7. Department of Health. More care, less pathway- A review of the Liverpool care pathway 2013 [Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212450/Liverpool\\_Care\\_Pathway.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf) accessed May 2 2017.
8. Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry The Stationary Office: London, England; 2013 [updated 2013//. Available from: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry> accessed August 4 2017.
9. Sinclair S, Norris JM, McConnell SJ, et al. Compassion: a scoping review of the healthcare literature. *BMC Palliat Care* 2016;15:6. doi: 10.1186/s12904-016-0080-0
10. Papadopoulos I, Zorba A, Koulouglioti C, et al. International study on nurses' views and experiences of compassion. *Int Nurs Rev* 2016;63(3):395-405. doi: 10.1111/inr.12298
11. Papadopoulos I, Taylor G, Ali S, et al. Exploring Nurses' Meaning and Experiences of Compassion: An International Online Survey Involving 15 Countries. *J Transcult Nurs* 2015 doi: 10.1177/1043659615624740
12. Van Der Cingel M. Compassion and professional care: exploring the domain. *Nurs Philos* 2009;10(2):124-36. doi: 10.1111/j.1466-769X.2009.00397.x
13. Van Der Cingel M. Compassion in care: a qualitative study of older people with a chronic disease and nurses. *Nurs Ethics* 2011;18(5):672-85. doi: 10.1177/0969733011403556
14. Fernando AT, 3rd, Consedine NS. Beyond compassion fatigue: the transactional model of physician compassion. *J Pain Symptom Manage* 2014;48(2):289-98. doi: 10.1016/j.jpainsymman.2013.09.014
15. Fernando AT, 3rd, Consedine NS. Barriers to Medical Compassion as a Function of Experience and Specialization: Psychiatry, Pediatrics, Internal Medicine, Surgery, and General Practice. *J Pain Symptom Manage* 2017 doi: 10.1016/j.jpainsymman.2016.12.324
16. Streiner DL, Norman GR, Cairney J. Health measurement scales : a practical guide to their development and use. Fifth edition. ed. Oxford: Oxford University Press 2015.



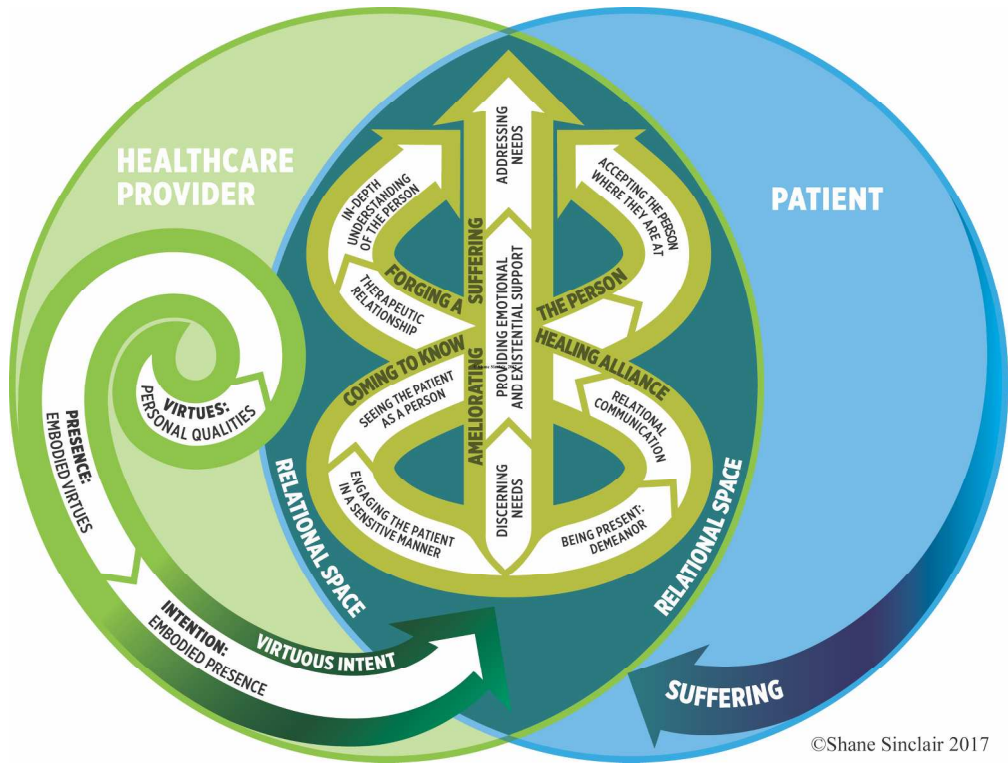
17. Sinclair S, Russell LB, Hack TF, et al. Measuring Compassion in Healthcare: A Comprehensive and Critical Review. *The Patient: Patient Centred Outcomes Research* 2016 doi: 10.1007/s40271-016-0209-5
18. Beattie M, Murphy DJ, Atherton I, et al. Instruments to measure patient experience of healthcare quality in hospitals: a systematic review. *Syst Rev* 2015;4:97. doi: 10.1186/s13643-015-0089-0
19. Sinclair S, McClement S, Raffin-Bouchal S, et al. Compassion in Health Care: An Empirical Model. *J Pain Symptom Manage* 2016;51(2):193-203. doi: 10.1016/j.jpainsymman.2015.10.009
20. Vivino BL, Thompson BJ, Hill CE, et al. Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research* 2009;19(2):157-71.
21. Way D, Tracy SJ. Conceptualizing compassion as recognizing, relating and (re) acting: A qualitative study of compassionate communication at hospice. *ComM* 2012;79
22. Ghaljeh M, Iranmanesh S, Nayeri ND, et al. Compassion and care at the end of life: oncology nurses' experiences in South-East Iran. *International Journal of Palliative Nursing*;22(12):588-97.
23. Lown BA, Rosen J, Marttila J. An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health Aff (Millwood)* 2011;30 doi: 10.1377/hlthaff.2011.0539
24. Graber DR, Mitcham MD. Compassionate clinicians: take patient care beyond the ordinary. *Holist Nurs Pract* 2004;18(2):87-94.
25. Kvangarsnes M, Torheim H, Hole T, et al. Nurses' perspectives on compassionate care for patients with exacerbated chronic obstructive pulmonary disease. *J Allergy Ther* 2013;4 doi: 10.4172/2155-6121.1000158
26. Lloyd M, Carson A. Making compassion count: Equal recognition and authentic involvement in mental health care. *Int J Consumer Stud* 2011;35 doi: 10.1111/j.1470-6431.2011.01018.x
27. Bray L, O'Brien MR, Kirton J, et al. The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students. *Nurse Educ Today* 2014;34 doi: 10.1016/j.nedt.2013.06.017
28. Armstrong AE, Parsons S, Barker PJ. An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study. *J Psychiatr Ment Health Nurs* 2000;7(4):297-305.
29. Skaff KO, Toumey CP, Rapp D, et al. Measuring compassion in physician assistants. *JAAPA* 2003;16
30. Horsburgh D, Ross J. Care and compassion: the experiences of newly qualified staff nurses. *J Clin Nurs* 2013;22(7-8):1124-32. doi: 10.1111/jocn.12141
31. Department of Health. Compassion in Practice. Nursing, Midwifery and Care Staff. Our Vision and Strategy 2012 [Available from: <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> accessed May 2 2017.
32. Kneafsey R, Brown S, Sein K, et al. A qualitative study of key stakeholders' perspectives on compassion in healthcare and the development of a framework for compassionate interpersonal relations. *J Clin Nurs* 2016;25(1-2):70-9. doi: 10.1111/jocn.12964
33. McCaffrey G, McConnell S. Compassion: a critical review of peer-reviewed nursing literature. *J Clin Nurs* 2015;24(19-20):3006-15. doi: 10.1111/jocn.12924



- 1  
2  
3 34. Perez-Bret E, Altisent R, Rocafort J. Definition of compassion in healthcare: a systematic  
4 literature review. *Int J Palliat Nurs* 2016;22(12):599-606. doi:  
5 10.12968/ijpn.2016.22.12.599  
6  
7 35. R. F. Report of the Mid Staffordshire NHS Foundation Trust public inquiry. *London: The*  
8 *Stationary office* 2013  
9  
10 36. Callwood A, Cooke D, Allan H. Developing and piloting the multiple mini-interview in pre-  
11 registration student midwife selection in a UK setting. *Nurse Educ Today*  
12 2014;34(12):1450-4. doi: 10.1016/j.nedt.2014.04.023  
13  
14 37. Willis L. Raising the Bar. Shape of Caring: A Review of the Future Education and Training  
15 of Registered Nurses and Care Assistants 2015 [accessed May 2 2017].  
16  
17 38. Strauss AL, Corbin JM. Basics of qualitative research : grounded theory procedures and  
18 techniques. Newbury Park, Calif.: Sage Publications 1990.  
19  
20 39. Sinclair S, Beamer K, Hack TF, et al. Sympathy, empathy, and compassion: A grounded  
21 theory study of palliative care patients' understandings, experiences, and preferences.  
22 *Palliat Med* 2017;31(5):437-47. doi: 10.1177/0269216316663499  
23  
24 40. Sinclair S, Torres MB, Raffin-Bouchal S, et al. Compassion training in healthcare: what are  
25 patients' perspectives on training healthcare providers? *BMC Med Educ* 2016;16:169. doi:  
26 10.1186/s12909-016-0695-0  
27  
28 41. Glaser BG, Strauss AL. The discovery of grounded theory; strategies for qualitative research.  
29 Chicago,: Aldine Pub. Co. 1967.  
30  
31 42. Corbin JM, Strauss AL. Basics of qualitative research : techniques and procedures for  
32 developing grounded theory. Fourth edition. ed. Los Angeles: SAGE 2015.  
33  
34 43. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research  
35 (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*  
36 2007;19(6):349-57. doi: 10.1093/intqhc/mzm042  
37  
38 44. Gilbert P. The origins and nature of compassion focused therapy. *Br J Clin Psychol*  
39 2014;53(1):6-41. doi: 10.1111/bjc.12043  
40  
41 45. Jazaieri H, Jinpa GT, McGonigal K, et al. Enhancing compassion: A randomized controlled  
42 trial of a compassion cultivation training program. *Journal of Happiness Studies*  
43 2013;14(4):pp. doi: 10.1007/s10902-012-9373-z  
44  
45 46. Seppala EM, Hutcherson CA, Nguyen DT, et al. Loving-kindness meditation: a tool to  
46 improve healthcare provider compassion, resilience, and patient care. *Journal of*  
47 *Compassionate Health Care* 2014;1(1):5. doi: 10.1186/s40639-014-0005-9  
48  
49 47. Gilbert P. The origins and nature of compassion focused therapy. *Br J Clin Psychol* 2014;53  
50 doi: 10.1111/bjc.12043  
51  
52 48. van der Cingel M. Compassion: the missing link in quality of care. *Nurse Educ Today*  
53 2014;34(9):1253-7. doi: 10.1016/j.nedt.2014.04.003  
54  
55 49. Zamanzadeh V, Valizadeh L, Rahmani A, et al. Factors facilitating nurses to deliver  
56 compassionate care: a qualitative study. *Scand J Caring Sci* 2017 doi: 10.1111/scs.12434  
57  
58 50. Halifax J. A heuristic model of enactive compassion. *Curr Opin Support Palliat Care*  
59 2012;6(2):228-35. doi: 10.1097/SPC.0b013e3283530f8e  
60  
61 51. Smith R. Stratified, personalised, or precision medicine. *The BMJ Opinion* 2012  
62  
63 52. Singer T, Klimecki OM. Empathy and compassion. *Curr Biol* 2014;24(18):R875-8. doi:  
64 10.1016/j.cub.2014.06.054

- 1  
2  
3 53. Post SG, Ng LE, Fischel JE, et al. Routine, empathic and compassionate patient care:  
4 definitions, development, obstacles, education and beneficiaries. *J Eval Clin Pract*  
5 2014;20(6):872-80. doi: 10.1111/jep.12243  
6  
7 54. Bloom P. *Against Empathy: The Case for Rational Compassion*: Harper Collins: New York  
8 2016.  
9 55. Wilber K. *One Taste: Daily Reflections on Integral Spirituality*: Shambhala Publications  
10 2000.  
11 56. Rogers CR. *A Theory of Therapy, Personality, and Interpersonal Relationships: As*  
12 *Developed in the Client-centered Framework*: New York, NY: McGraw-Hill 1959.  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



208x157mm (300 x 300 DPI)

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

Category	Theme
Virtuous Intent	Virtues: Personal Qualities
	Presence: Embodied Virtues
	Intention: Embodied Presence
Relational Space	
Coming to Know The Person	Engaging the Patient in a Sensitive Manner
	Seeing the Patient as a Person
	Accepting The Person Where They Are At
Forging a Healing Alliance	Being Present: Demeanor
	Relational Communication
	Therapeutic Relationship
	In-Depth Understanding of the Person
Ameliorating Suffering	Discerning Needs
	Providing Emotional and Existential Support
	Addressing Needs

**Table 1**

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
<b>Domain 1: Research team and reflexivity</b>		
Personal Characteristics		
1.	Interviewer/facilitator or	Which author/s conducted the interview or focus group? <i>The corresponding author (SS) and a research assistant</i> <b>Pg. 9</b>
2.	Credentials	What were the researcher's credentials? (E.g. PhD, MD) <i>. The research team consisted of 7 PhD trained researchers (SS, TH, SM, SRB, KS, HMC, PS) (5 of whom were experts in qualitative methods (SS, TH, SM, SRB, KS) ); 2 palliative care MD (NH, AS)</i> <b>Pg. 13</b>
3.	Occupation	What was their occupation at the time of the study? <i>All of the research team had academic appointments, while one researcher (AS) also had a clinical position working on a palliative care unit in Alberta Health Services.</i> <b>Pg. 1, pg 13</b>
4.	Gender	Was the researcher male or female? <i>The research assistant was a female. The research team consisted of 6 males, and 3 females.</i> <b>Pg. 1, pg. 13</b>
5.	Experience and training	What experience or training did the researcher have? <i>The research team has conducted a number of large qualitative studies utilizing grounded theory, ethnography and hermeneutics in addition to a track record conducting large multicenter trials.. The research assistant has considerable experience conducting qualitative interviews.</i> <b>Pg. 10, 13</b>
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement? <i>No</i> <b>Pg. 9</b>
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? (e.g. personal goals, reasons for doing the research) <i>No information was given to the participants about the</i>

researcher **Pg. 9**

8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? (e.g. <i>Bias, assumptions, reasons and interests in the research topic</i> ) <b>Pg. 9</b>
<b>Domain 2: study design</b>		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? (e.g. <i>grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i> ) <i>Grounded theory</i> <b>pg. 9&amp;13</b>
Participant selection		
10.	Sampling	How were participants selected? e.g. <i>purposive, convenience, consecutive, snowball</i> Participants were first informed about the study from through a education session and posters. <b>Pg. 6</b>
11.	Method of approach	How were participants approached? (e.g. <i>face-to-face, telephone, mail, email</i> ) <i>Convenience, snowball and theoretical sampling (Grounded Theory) were utilized.</i> <b>Pg. 6, 9</b>
12.	Sample size	How many participants were in the study? <i>A total of 57 participants participated in the study</i>
13.	Non-participation	How many people refused to participate or dropped out? Reasons? <i>None</i> <b>P. 9</b>
Setting		
14.	Setting of data collection	Where was the data collected? e.g. <i>home, clinic, workplace</i> <i>All data was collected in a private room at participants places of work (hospice, home care offices, hospital unit)</i> <b>P.9</b>
15.	Presence of non-participants	Was anyone else present besides the participants and researchers? <b>No p.9</b>
16.	Description of sample	What are the important characteristics of the sample? e.g. <i>demographic data, date</i> <i>The sample is largely representative of a interdisciplinary healthcare team. 86% were female. Average years in palliative care was 11.8 years. A cross-section of Nurses, Physicians and other members</i>

of the healthcare team are represented. **P.8 (table 1)**

Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested? <i>The interview followed an interview guide for each of the three stages. As it was semi-structured, probing questions were used when appropriate to delve more into an area of topical interest P.9, 10-12 (guides)</i>
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many? <i>No. However some of the Stage 2 interview participants who were nominated by stage 1 focus group members (Snowball sampling) also participated in the focus groups (n=3). Pg. 9</i>
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data? <i>All interviews were audio-recorded then given to a transcriptionist. All participants were made aware of the recording prior to signing the informed consent form pg.10</i>
20.	Field notes	Were field notes made during and/or after the interview or focus group? <i>The interviewer recorded field notes of non-verbal cues throughout the interview Pg. 10</i>
21.	Duration	What was the duration of the interviews or focus group? <i>Interviews lasted for 1 – 1 ½ hours pg. 9</i>
22.	Data saturation	Was data saturation discussed? <i>Yes. This was estimated during the design phase of the study, revisited after 25 interviews were conducted and reached after 7 focus groups (n=35) and 15 individual interviews. Pg. 7</i>
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction? <i>Transcripts were independently verified against the audio file by both the transcriptionist and the research assistant. When questions of clarification were needed about individual participants response the research assistant contacted the participant. As grounded theory is an iterative research method participant responses in the initial focus groups and interviews were followed up with subsequent participants as necessary. We also had a dedicated stage that involved member checking with a small sample of participants. Pg.10</i>

### Domain 3: analysis and findings



## Data analysis

24.	Number of data coders	How many data coders coded the data? The analysis team consisted of 5 coders (SS, TH, SM, SRB, KS) <b>Pg. 13</b>
25.	Description of the coding tree	Did authors provide a description of the coding tree? <i>No Straussian Grounded Theory doesn't use a coding tree. The authors did however provide a detailed account of the coding process including the use of a coding schema. <b>Pg. 13</b></i>
26.	Derivation of themes	Were themes identified in advance or derived from the data? <i>All themes were derived from the data <b>Pg. 13</b></i>
27.	Software	What software, if applicable, was used to manage the data? <i>No software was used for coding <b>N/A</b></i>
28.	Participant checking	Did participants provide feedback on the findings? <i>Yes, as mentioned above (#23), we contacted study participants directly to verify data as necessary. We also had an intentional member-checking focus group with a group of study participants related to the compassion model and to ensure that we had accurately represented their views (Stage 3). <b>Pg. 13</b></i>
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? (e.g. participant number) <i>Yes, participant quotation were use to support / illustrate the findings. All participants were referred to by a number to maintain participant anonymity <b>Pg. 15-25</b></i>
30.	Data and findings consistent	Was there consistency between the data presented and the findings? <i>Yes <b>Pg. 13-15</b></i>
31.	Clarity of major themes	Were major themes clearly presented in the findings? <i>Yes both major themes and subthemes were presented in the results <b>Pg. 15-25 and Figure 1 and 2</b></i>
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes? <i>Yes, all themes and subthemes were addressed and discussed <b>Pg. 13, 15-25, Figure 1 and 2</b></i>



# BMJ Open

## What are Healthcare Providers' Understandings and Experiences of Compassion? The Healthcare Compassion Model: A Grounded Theory Study of Healthcare Providers in Canada

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2017-019701.R2
Article Type:	Research
Date Submitted by the Author:	22-Jan-2018
Complete List of Authors:	Sinclair, Shane; University of Calgary, Faculty of Nursing; University of Calgary Cumming School of Medicine, Palliative Care Hack, Thomas; University of Manitoba, Rady Faculty of Health Sciences; University of Central Lancashire, School of Health Sciences Raffin, Shelley; University of Calgary, Nursing McClement, Susan; University of Manitoba, Rady Faculty of Health Sciences; CancerCare Manitoba, Research Institute in Oncology Hematology Stajduhar, Kelli ; University of Victoria, School of Nursing and Institute on Aging and Lifelong Health Singh, Pavneet; University of Calgary, Faculty of Nursing Hagen, Neil; University of Calgary, Oncology, Cumming School of Medicine; University of Calgary Cumming School of Medicine, Clinical Neurosciences and Medicine Sinnarajah, Aynharan; University of Calgary, Palliative Care Chochinov, Harvey Max; University of Manitoba, Psychiatry; CancerCare Manitoba, Research Institute in Oncology Hematology
<b>Primary Subject Heading</b>:	Patient-centred medicine
Secondary Subject Heading:	Qualitative research, General practice / Family practice, Communication, Palliative care
Keywords:	compassion, compassionate care, grounded theory, healthcare providers, model, QUALITATIVE RESEARCH

SCHOLARONE™  
Manuscripts

1  
2  
3 What are Healthcare Providers' Understandings and Experiences of Compassion? The  
4  
5 Healthcare Compassion Model: A Grounded Theory Study of Healthcare Providers in Canada  
6  
7  
8

9 Shane Sinclair PhD,<sup>1,2</sup> Thomas F. Hack PhD,<sup>3,4,5</sup> Shelley Raffin-Bouchal PhD,<sup>1</sup> Susan  
10 McClement PhD,<sup>3,4</sup> Kelli Stajduhar PhD<sup>6</sup>, Pavneet Singh PhD<sup>1</sup>, Neil A. Hagen MD, FRCPC,<sup>2,8</sup>  
11 Aynharan Sinnarajah MD MPH CCFP (PC),<sup>2,7</sup> Harvey Max Chochinov MD, PhD, FRCPC,  
12 FRSC<sup>3,9</sup>  
13  
14  
15

- 16 1. Faculty of Nursing, University of Calgary, 2500 University Drive NW Calgary, Alberta  
17 Canada. T2N 1N4.
- 18 2. Department of Oncology, Cumming School of Medicine, University of Calgary, 2500  
19 University Drive NW, Calgary, Alberta, Canada. T2N 1N4.
- 20 3. Research Institute in Oncology Hematology, Cancer Care Manitoba, 4005E – 675  
21 McDermot, Winnipeg, Manitoba, Canada. R3E 0V9.
- 22 4. College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, 89 Curry  
23 Place, Winnipeg, Manitoba, Canada. R3T 2N2.
- 24 5. School of Health Sciences, University of Central Lancashire, Brook Building (4<sup>th</sup> Floor,  
25 Room BB440), Preston, United Kingdom PR1 2HE
- 26 6. School of Nursing and Institute on Aging and Lifelong Health, University of Victoria, R  
27 Hut, Room 103, Victoria, British Columbia, Canada. V8P 5C2.
- 28 7. Palliative / End of Life Care, Calgary Zone, Alberta Health Services, 710 South Tower,  
29 1403 – 29<sup>th</sup> Street NW, Calgary, Alberta, Canada. T2N 2T8.
- 30 8. Departments of Clinical Neurosciences and Medicine, Cumming School of Medicine,  
31 University of Calgary, 2500 University Drive NW, Calgary, Alberta, Canada. T2N 1N4.
- 32 9. Department of Psychiatry, University of Manitoba, 771 Bannatyne Avenue, Winnipeg,  
33 Manitoba, Canada. R3E 3N4.  
34  
35  
36  
37

38 Word Count: 3874 (excluding title page, abstract, references, figures, tables and participant  
39 quotes). 5600 (including participant quotes).  
40

41 Keywords: compassion; compassionate care; grounded theory; healthcare providers; model;  
42 qualitative  
43  
44

45 Corresponding author: Dr. Shane Sinclair

46 Address: Faculty of Nursing, University of Calgary,  
47 PF 2280, 2500 University Drive NW Calgary, Alberta Canada. T2N 1N4

48 Tel: 403.220.2925

49 e-mail: [sinclair@ucalgary.ca](mailto:sinclair@ucalgary.ca)

50 fax: 403.284.4803  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## ABSTRACT

**Background:** Healthcare providers are considered the primary conduit of compassion in healthcare. Although most healthcare providers desire to provide compassion, and patients and families expect to receive it, an evidence based understanding of the construct and its associated dimensions from the perspective of healthcare providers is needed.

**Objectives:** The aim of this study was to investigate healthcare providers' perspectives and experiences of compassion in order to generate an empirically derived, clinically informed model.

**Design:** Data was collected via focus groups with frontline healthcare providers and interviews with peer-nominated exemplary compassionate healthcare providers. Data was independently and collectively analyzed by the research team in accordance with Straussian grounded theory.

**Setting and Participants:** 57 healthcare providers were recruited from urban and rural palliative care services spanning hospice, homecare, hospital based consult teams, and a dedicated inpatient unit within Alberta, Canada.

**Results:** Five categories and 13 associated themes were identified, illustrated in the Healthcare Provider Compassion Model depicting the dimensions of compassion and their relationship to one another. Compassion was conceptualized as -- A virtuous and intentional response to know a person, to discern their needs, and ameliorate their suffering through relational understanding and action.

**Conclusions:** An empirical foundation of healthcare providers' perspectives on providing compassionate care was generated. While the dimensions of the Healthcare Provider Compassion

1  
2  
3 Model were congruent with the previously developed Patient Model, further insight into  
4  
5 compassion is now evident. The Healthcare Provider Compassion Model provides a model to  
6  
7 guide clinical practice and research focused on developing interventions, measures, and  
8  
9 resources to improve it.  
10  
11

12  
13 Keywords: compassion; compassionate care; grounded theory; healthcare providers; model;  
14  
15 qualitative  
16  
17

### 18 19 **Strengths and limitations of this study:**

- 20  
21 • This grounded theory study delineates the key dimensions of compassion from direct  
22 reports of a large qualitative sample (n=57) consisting of frontline healthcare providers,  
23 nominated exemplary compassionate healthcare providers, and key stakeholders across  
24 three distinct data collection phases.  
25  
26
- 27  
28 • A healthcare provider definition and empirical model of compassion extends the largely  
29 theoretical nature of the compassion literature to a clinically informed and clinically  
30 relevant model that can serve as a framework for policy, practice, education and research.  
31  
32
- 33  
34 • By recruiting healthcare providers working primarily in palliative care, substantial  
35 variance in perspectives and experiences of compassion based on other practice settings,  
36 patient populations, subspecialties and cultures were not necessarily captured.  
37  
38
- 39  
40 • By using purposive, snowball and theoretical sampling techniques, our sample may have  
41 been overly represented by like-minded individuals who had an affinity toward the topic  
42 and their ability to provide compassion.  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## BACKGROUND

Compassion is considered a vital component of quality healthcare. Healthcare providers (HCPs) are increasingly recognized as the primary, front line conduits of compassionate care, and not surprisingly, the first target of criticism when compassion is lacking.<sup>1-8</sup> Despite their instrumental role in delivering compassionate care within the healthcare system, research investigating HCPs' understandings and experiences of providing compassionate care directly is nascent.<sup>9</sup> Work investigating nursing<sup>10-13</sup> and physician perspectives<sup>14 15</sup> have begun to advance the field from what was previously a largely theoretical body of knowledge toward an evidence and clinically informed field of research. The current study is aimed to extend this work in order to develop an empirically derived, clinically informed, model of compassion. It intends to outline key dimensions of compassionate care in the context of healthcare and also to characterize the nature of compassion from the perspective of interdisciplinary healthcare providers who are charged and challenged to provide it. Earlier research largely utilize *a priori* definitions of compassion, or definitions based on factors or situations HCPs associate with compassion. In contrast we began by asking HCPs directly about their understanding of compassion. Obtaining direct participant reports on the construct of interest is recognized as an important step in establishing construct validity particularly for subjective and relational constructs such as compassion,<sup>16-18</sup> significantly effecting the models, measures and research that are produced from them.

Recently, our research team identified a similar research need — a lack of direct patient accounts on the nature of compassion in healthcare – leading to the development of an empirically derived, patient informed model of compassion.<sup>19</sup> This study generated the following patient informed definition of compassion: “a virtuous response that seeks to address the

1  
2  
3 suffering and needs of a person through relational understanding and action”.<sup>19</sup> Much like the  
4 dearth of patient perspectives in the literature, we were able to identify only a few studies  
5 investigating HCP perspectives of compassion, most of which utilized predetermined researcher  
6 generated definitions rather than establishing construct validity from the perspective of  
7 individuals actually involved in providing compassion.<sup>10 11 13 20 21</sup> Together, these and other  
8 published studies identified a wide array of behaviours, skills, and attitudes associated with  
9 compassion at the bedside including: relating to the patient as an individual;<sup>21-26</sup> re-acting to  
10 suffering;<sup>13 21 27</sup> presence;<sup>13</sup> giving time and listening,<sup>13 23 28 29</sup> understanding patients’ feelings,<sup>13</sup>  
11 <sup>28 30</sup> confronting,<sup>13</sup> caring,<sup>13</sup> a moral virtue;<sup>28</sup> intelligent kindness;<sup>31</sup> empathy,<sup>11 27 28 30</sup> assisting  
12 patients to make their own decisions,<sup>28</sup> acting in patients’ best interests.<sup>28</sup> In the few studies that  
13 asked participants to define compassion directly, psychotherapists identified it as “connecting the  
14 clients suffering and promoting change through action”.<sup>20</sup> A group of healthcare stakeholders  
15 defined compassion as “the combination of underpinning emotions (such a as sympathy and  
16 empathy), with altruistic values (particularly a desire to help others), which together motivated  
17 an individual to take action that would ultimately be experienced as ‘care by the recipient’”.<sup>32</sup>  
18 While these studies provide insight into conceptualizations of compassion from the perspective  
19 of providers, they are yet limited in their: representativeness of interdisciplinary perspectives;  
20 specificity in identifying the key dimensions of compassion and their relationship to one another;  
21 delineation of compassion to related concepts such as care, empathy and sympathy; and  
22 methodological rigor.<sup>9 33 34</sup>

23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49 The consequences of these issues extend beyond the realm of scholarship, having direct  
50 application to healthcare education and practice. Increasingly, governments, patients, and  
51 healthcare institutions consider compassion a clinical necessity. Compassion has been considered  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 a standard of care,<sup>4 35</sup> an admission requirement for healthcare education,<sup>35-37</sup> and a practice  
4  
5 competency.<sup>2 35</sup> As a result, educators, HCPs and trainees are encouraged, expected, and  
6  
7 increasingly held accountable for their competency in providing compassion – but as yet without  
8  
9 the benefit of a rubric defining and delineating the key attitudes, knowledge, skills and  
10  
11 behaviours that are to be taught and learned.  
12  
13

14  
15 To address these gaps, this grounded theory study investigated the perspectives and  
16  
17 experiences of HCPs on the construct of compassion, in order to develop an empirical model  
18  
19 illustrating its key dimensions and their relationship to one another.  
20

## 21 **METHODS**

### 22 **Study population**

23  
24  
25 After receiving approval to conduct this study from the University of Calgary Conjoint  
26  
27 Health Research Ethics Board (#REB 15-1999), HCPs were recruited through convenience  
28  
29 sampling, snowball sampling, and theoretical sampling.<sup>38</sup> With these techniques, certain types of  
30  
31 participants (gender, ethnicity, profession) are sampled to ensure a heterogeneous sample and to  
32  
33 address gaps or under developed facets of the emerging model (such as underdeveloped  
34  
35 categories or themes, and unanticipated findings). HCPs were recruited between October 2015  
36  
37 and September 2016 from the palliative care services of the Calgary Zone in Alberta, Canada.  
38  
39 The services include urban and rural hospice, homecare, hospital based consult teams, and a  
40  
41 dedicated inpatient palliative care unit. HCPs were eligible to participate if they: i) were at least  
42  
43 18 years of age; ii) were able to read and speak English; iii) worked in palliative care for at least  
44  
45 6 months; and iv) were able to provide written informed consent. While all participants currently  
46  
47 worked in palliative care, many of the study participants had additional, extensive clinical  
48  
49 experience in areas of clinical care beyond palliative care. Participants' questions or concerns  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 were addressed, and consent was obtained prior to participation in focus groups and interviews.  
4  
5 Although sample sizes are not predetermined in qualitative studies, based on our own research  
6  
7 involving similar methodology,<sup>19 39 40</sup> we aimed to recruit approximately 50 HCPs. Ultimately,  
8  
9  
10 57 participants were required to reach data saturation (Table 1).  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



**Table 1: Demographic Information** (Numbers expressed as percentages and (n))

<b>Mean Age (Years)</b>	48.6
Men	14 (8)
Women	86 (49)
<b>Mean number of years in palliative care (range)</b>	11.8
<b>Employment Status*</b>	
Full-time	57.8 (33)
Part-time	33.3 (19)
Casual	7.0 (4)
<b>Profession</b>	
Registered Nurse	45.6 (26)
Physicians	22.8 (13)
Healthcare Aide	7.0 (4)
Spiritual Care Specialist	5.2 (3)
Unit Clerk	3.5 (2)
Occupational Therapist	3.5 (2)
Licensed Practical Nurse	3.5 (2)
Housekeeper	1.7 (1)
Social Worker	1.7 (1)
Psychologist	1.7 (1)
Respiratory Therapist	1.7 (1)
Physiotherapist	1.7 (1)
<b>Care Setting**</b>	
Home Care	29.8 (17)
Hospice	26.3 (15)
Hospital Dedicated Palliative Care Unit	21.0 (12)
Hospital Palliative Care Consult Service	14.0 (8)
Palliative Care Administrator	7.0 (4)
Outpatient Oncology Palliative Care Consult Service	5.2 (3)
Rural Palliative Care Consult Service	5.2 (3)
Other	1.7 (1)
<b>Religious Affiliation*</b>	
Christian	52.6 (30)
Buddhist	7.0 (4)
Jewish	3.5 (2)
Muslim	1.7 (1)
Hindu	1.7 (1)
None	31.5 (18)
<b>Religious and Spiritual Status*</b>	
Spiritual and Religious	33.3 (19)
Spiritual but not Religious	56.1 (32)
None	8.7 (5)

\* The total for these categories is less than 100% due to non-responses by participants

\*\*The total for these categories is more than 100% due to some participants working in multiple care settings

## Data collection

Data were collected via an interview guide (Tables 2-4) using focus groups and one-on-one semi-structured interviews across three study stages. In the first stage, 35 frontline HCPs participated in one of 7 focus groups, ranging from 1-1.5 hours in duration. Meetings were held in a private conference room at their place of work. The purpose of the focus groups was to obtain an understanding of the perspective of a broad cohort of interdisciplinary care providers involved in direct patient care. The second stage involved interviews with HCPs who were nominated by their peers as exemplary compassionate healthcare providers in order to elicit an advanced understanding of the qualities, skills knowledge and behaviours associated with compassion from the perspective of clinical experts. Exemplary compassionate care providers were nominated by focus group participants, via a question within the study demographic questionnaire that asked them to nominate up to two of their interdisciplinary peers whom they considered to be exemplary compassionate healthcare providers. A total of 15 individual interviews were conducted in a private room at their place of work, with 3 of these individuals having also participated in Stage 1 focus groups. The final stage of data collection occurred through two focus groups with Stage 1 and 2 study participants (n=5) and key stakeholders (n=10) (administrators, clinical leads and health faculty educators) in order to assess the validity of the model and facilitate knowledge translation and future research directions. Stage 3 focus groups were also used to further fulfill the criteria for rigor in qualitative studies: fit (categories should emerge from the data and not the pre-existing perspective of the researchers); work (the ability for the theory to explain and interpret behaviour in the area of study); relevance (the theory is relevant to clinical care); and modifiability (that the theory is adaptable to different contexts and as new data becomes available).<sup>41</sup> All focus groups and interviews were conducted

by an experienced qualitative interviewer who was not a member of the analysis team, with the exception of the first two focus groups in Stages 1 and 3, which were conducted by the Principal Investigator (SS) for training and standardization purposes. The interviewer was neither a member of the clinical team and had no previous relationship with study participants. In addition to a formal orientation and protocol training session in accordance with Straussian grounded theory, we mitigated against interviewer bias by utilizing a standardized interview guide and instructing the interviewer to focus on active listening, participant responses and predetermined prompting questions (Table 2). The focus groups and interviews were audio-recorded and transcribed verbatim, with contextual content (such as emotions and non-verbal communication) being recorded in the form of field notes. The verbatim transcripts were independently verified against the audio recording by the interviewer and a member of the analysis team (SS). The fidelity of each focus group and interview session was further ensured by having the analysis team analyze the interviewer's adherence to the protocol and the performance of the interview questions in each transcript, and providing feedback and correction.

**Table 2: Stage 1 Focus Group Guiding Questions**

1. Based on your professional and personal experience, what does compassion mean to you?
2. Can you give me an example of when you felt you provided or witnessed care that was compassionate? [What do you feel were the key aspects of these interactions?]
3. What do you feel are the major influencers of compassionate care in your practice?
4. What do you feel inhibits your ability to provide compassionate care?
5. Do you think patients and/or family members influence the provision of compassionate care? [How or how not?], [If yes, what characteristics of patients and/or families, do you feel facilitate or inhibit compassionate care?]
6. What advice would you give other healthcare providers on providing compassionate care?

7. Do you think we can train people to be compassionate? [If so, how]?
8. Based on your experience what role, if any, do you feel compassion has in alleviating end of life distress? [What happens when compassionate care is lacking?]
9. What impact does providing compassionate care have on you personally and professionally?
10. Is there anything related to compassion that we have not talked about today that you think is important or were hoping to talk about?

**Table 3: Stage 2 Interview Guiding Questions**

1. You have been identified by your peers as possessing great skill in providing compassionate care. What do you feel might be some of the reasons for this recognition? [Why do you think others identify you as a compassionate healthcare provider?]
2. In your own terms, how would you define compassion? [What does compassion mean to you?]
3. How did you become a compassionate caregiver? [What beliefs, situations, individuals and/or life experiences in your life and practice do you feel have informed your understanding and provision of compassionate care? Have you always been that way? [Were you always like that? How did you learn it? Can it be learned?]
4. If you reflect back on your current position, can you walk me through the best example of when you provided compassionate care? [What constitutes compassionate care in an admin/phone triage role? Please guide me through the process of this encounter in a sequential fashion, highlighting the key components of this interaction from the initial approach to the consequences of this interaction?]
5. Based on your professional and personal experiences, what shapes your compassionate care?
6. If you were responsible for training students in compassionate care, how would you go about it? [What would you teach them?]
7. Is there anything that gets in the way of your ability to provide compassionate care?
8. How do patients and/or families influence how your ability to provide compassionate care? [What characteristics of patients and/or families, do you feel facilitate or inhibit compassionate care?]

9. A number of participants have identified the healthcare system as being a significant factor in delivering compassionate care? From your perspective, how does/can the healthcare system facilitate or inhibit compassionate care?
10. In light of the things you've just identified as facilitators and barriers, what suggestions would you have for enhancing compassion at a systems level? [Where and what would you focus your efforts on in order to enhance compassion at a systems level]?
11. From what you've told me so far, it sounds like compassionate care is important. So what happens [to patients, families or HCPs] when compassionate care is lacking?
12. What impact does providing compassionate care have on you personally and professionally?
13. Our focus group participants, previous studies and review of the literature have reported how critical and fundamental compassion is to providing quality patient care, but we also know that compassionate care varies. So given all that we know about the importance of compassionate care, why aren't healthcare providers more compassionate?
14. Before we end, given all we've talked about, I just want to revisit one of the first questions I asked, which is how do you personally define compassion? [In light of our discussion, what does compassion mean to you?]
15. Is there anything related to compassion that we have not talked about today that you think is important or were hoping to talk about?

**Table 4: Stage 3 Focus Group Questions**

1. Does the healthcare provider model of compassion make sense to you? [Does it resonate with you]? [Why or Why not]?
2. Do you feel there is anything missing from the model?
3. How do you feel this model might be relevant to you and your work?
4. How do you suggest the model might be integrated into healthcare practice and education?
5. Is there anything related to the model that we have not talked about today that you think is important or were hoping to talk about?

## Data Analysis

This study was guided by Straussian grounded theory, an inductive, iterative, qualitative method that aims to define and construct an empirically grounded account of a topic grounded in study data within a naturalistic setting.<sup>38 41 42</sup> Grounded theory is particularly useful method when investigating social processes related to a complex phenomena that are based in the subjective experience of participants.<sup>41 42</sup> Five members of the research team, who have extensive research and teaching experience in qualitative methods (SS, TH, SM, SRB, KS) analyzed the data in accordance with the three stages of analysis. The analysis team was comprised of two males and three females and professionally consisted of three nurses, a psychologist and a spiritual care provider. The first stage, open coding, involved each individual independently analyzing each transcript in a line-by-line manner. Individual codes were recorded in the margin, with subsequent codes being compared and contrasted with previous codes—an analytical process known as the constant comparative technique.<sup>38</sup> After independently analyzing each set of 2-3 transcripts, the analysis team (SS, TH, SM, SRB, KS) met to compare their individual codes. They read through each transcript again in a line-by-line fashion, settling differences between individual's codes and delineating incidences in the transcript that were non-specific to compassion through a process of consensus. This produced a 'master' coded transcript for each interview and focus group. Rigour was further assured by having three physician members (AS, NH, HMC) of the study team, who were not involved in analyzing the interviews or focus groups, independently audit the coding process. Axial coding, the second stage of analysis, began at a 3-day face-to-face analysis team meeting after Stage 1 focus group data had been analyzed. The purpose of axial coding is to compare codes with other data, to combine and

1  
2  
3 collapse codes, and to cluster codes into categories and themes. Axial coding generated a coding  
4  
5 schema which was used and modified in subsequent interviews. The third stage of analysis,  
6  
7 selective coding involved integrating and refining categories and themes after the model and core  
8  
9 variable were identified, delimiting coding to those categories that relate to the core variable. The  
10  
11 model was finalized at a subsequent 3-day meeting and then vetted through the study participant  
12  
13 and a key stakeholder focus groups. This study met the 32 consolidated criteria for reporting  
14  
15 qualitative research (COREQ).<sup>43</sup>  
16  
17

## 18 19 RESULTS

20  
21 Five categories and thirteen associated themes emerged from the data (Figure 1). The  
22  
23 core variable, which describes phenomenon of interest and links the categories together, is: *a*  
24  
25 *virtuous, intentional response to know and understand a person and ameliorate their suffering.*  
26  
27 The key dimensions of compassionate care are illustrated in a model (Figure 2), which generated  
28  
29 a HCP definition of compassion: *A virtuous and intentional response to know a person, to*  
30  
31 *discern their needs, and ameliorate their suffering, through relational understanding and action.*  
32  
33

34  
35 \* **Figure 1. Elements of Compassion: Categories and Themes** (Please insert here)

36  
37 \* **Figure 2. Healthcare Provider Compassion Model** (Please insert here)

### 38 39 40 41 **Virtuous Intent**

42  
43 Participants provided insight into the innate qualities which served as the catalyst that  
44  
45 compassion flowed from and through. Compassion was not simply understood as an affective  
46  
47 response, but a response based in the virtues that participants brought into the clinical encounter.  
48  
49 The category of Virtuous Intent, *the purposeful desire to embody and express one's good and*  
50  
51 *noble qualities in professional practice*, was described by several participants as an internal  
52  
53 process of self/provider congruence.  
54  
55  
56  
57  
58  
59  
60

### Virtues: Personal Qualities

Study participants identified virtues as the primary motivator of compassion. While a few participants identified virtues as a collective whole, most participants listed individual virtues such as love, kindness, genuineness, care and peace which naturally distilled into this theme in an iterative manner. Virtues were conceptualized as *the good character or noble qualities embodied within HCPs that stimulated compassion*. In this study, virtues were not equated with morality, religion, or spirituality, although some participants did identify these as potential facilitators; rather, they were human qualities that could be developed through a variety of other means including family upbringing, role modelling, self-reflection, and life experience. As a result, while participants felt that every HCP possessed and could cultivate virtues, they acknowledged variation in these innate qualities based on personal and professional experiences, willingness, and circumstance. While compassion was conceptualized as a multi-dimensional construct (Figure 2), the other categories of the model had to flow through virtues of love, acceptance, honesty, genuineness, humility and kindness to be considered compassionate. Compassion's rootedness in HCPs virtues was viewed by participants as a distinguishing feature of compassion in comparison to other expressions of care (e.g. routine care, empathy, sympathy).

Genuine love for your fellow man, that helps you be compassionate and to want to care for people (Interview Participant 3).

When I think of empathy and I think of compassion, I think that compassion is a bit broader and deeper and more loving (Interview Participant 15).

I think you can say the right words, but I think there has to be genuineness behind it. And I think people pick up on that whether you're acting or not (Interview Participant 7).

### Presence: Embodied Virtues

Presence was understood as *the distillation and expression of personal virtues to others through the character of an individual*. In other words, according to participants, virtues in



1  
2  
3 relation to compassion, were not considered static traits, but needed to permeate through the  
4  
5 presence of HCPs into their practice. Since HCPs felt that patients could intuitively sense their  
6  
7 virtues and capacity for compassion, they emphasized the importance of self-awareness and  
8  
9 developing these inner qualities prior to interacting with the patient.  
10  
11

12 There's something in the caregiver that resides in the caregiver but it's sort of, there's this  
13 catalytic thing that happens when it comes into the presence of someone else's suffering  
14 and then something could catch fire or not (Stage 1 Focus Group Participant 12)  
15  
16

17 Being genuine, they can see that and they can feel that so... it's almost like an energy that  
18 occurs as well. They can feel it and you can feel it... I always say can I be vulnerable in  
19 their presence and try to equalize it and I don't necessarily disclose my human spirit but I  
20 think I release it in a way that allows them to bring it forward (Stage 1 Focus Group  
21 Participant 23).  
22  
23

24 Before we ever say a word, people feel from us who we are, in these beds and in these  
25 rooms. And that's compassion (Interview Participant 6).  
26  
27

#### 28 Intention: Embodied Presence

29  
30 Immediately prior to engaging with the person in suffering, many participants described  
31  
32 an intentional practice, whereby they adopted *a self-effacing and curious attitude toward the*  
33  
34 *patient and tried to orientate themselves to the patient's perspective*. In several participants, the  
35  
36 necessity for a self-effacing attitude to compassionate care was explicitly described. In contrast,  
37  
38 it was implicit in the responses of many of the exemplary compassionate caregivers, whom upon  
39  
40 being notified that they had been nominated, spontaneously indicated that they did not self-  
41  
42 identify as being particularly compassionate. This intentional process of concurrently demoting  
43  
44 oneself and trying to take the perspective of the patient, reflected participants' belief that  
45  
46 compassion involves forethought and choice. Compassion was described as being conveyed  
47  
48 through the virtues or energy that HCPs conveyed in interacting with a patient. Participants,  
49  
50 however, were clear that this didn't occur through happenstance, but through a process of self-  
51  
52 reflection whereby HCPs drew awareness to their internal state and intentionally tried to put  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 aside their own frustrations, needs, wishes and preconceptions about the patient in order to  
4  
5 practice compassion.  
6

7  
8 Everyone has the possibility to be compassionate. They just have to choose to be  
9 (Interview Participant 1).  
10

11  
12 It's almost like a different intentional way of being that you have to work on or cultivate  
13 (Stage 3 Focus Group Participant 1).  
14

15 I think compassion is about coming with an open, maybe even curious attitude of being  
16 able to be present with another individual... So being able to suspend what's going on for  
17 those few moments when you enter and so, you know it's kind of like you know  
18 envisioning as you approach the door and taking that deep breath and kind of cleansing  
19 yourself to walk into that room (Interview Participant 8).  
20  
21

## 22 23 **Relational Space**

24  
25 Participants situated the core categories of compassionate care within a broader relational  
26  
27 space, which was defined as *the context for compassion where the virtuous intent of the*  
28  
29 *caregiver engages the suffering of a person*. Relational space differed from other categories in  
30  
31 that it was not a mutually exclusive category, as the three categories 'Coming to Know the  
32  
33 Person'; 'Forging a Healing Alliance' and 'Ameliorating Suffering' were nested within it. This  
34  
35 was due to participants' belief that compassion was embedded in a relational approach that  
36  
37 traversed the three categories subsumed within it. Compassion was relational in that it was  
38  
39 regulated by an openness by patients to receive compassion and a willingness on the part of the  
40  
41 HCP to be professionally and personally impacted by the suffering of their patients.  
42  
43  
44

45  
46 Compassion involves two people or more I guess, but it's not just sort of one person I am  
47 being---I am exuding compassion. Like I think it needs to be given and received and I  
48 see it as kind of going back and forth. (Interview Participant 8)  
49

50  
51 It's not something that exists just within me. It's something that occurs between me and  
52 somebody else. (Interview Participant 1)  
53

## 54 55 **Coming to Know the Person**

56  
57  
58  
59  
60

1  
2  
3 Having established an initial connection to their patient within the relational space HCPs  
4 described an ongoing process of coming to know the person, *an attentive and sensitive approach*  
5 *that seeks to engage, see, accept, and understand the patient as a person.*  
6  
7

#### 8 9 10 Engaging the Patient in a Sensitive Manner

11  
12 HCPs described the importance of engaging the patient in an attentive and sensitive  
13 manner within the clinical encounter. This involved HCPs *attuning to the energy of the room, the*  
14 *patient's presence, and interpersonal cues in order to be attentive to the person and to develop*  
15 *an awareness of their background.* Many participants felt that this approach allowed them to  
16  
17 develop an appreciation of the patient's broader life story, to see the patient as a person, and  
18  
19 accept them where they were at.  
20  
21  
22  
23  
24  
25

26 This is the sensitive part you're matching their energy level for that time that they're in  
27 the hospice or that time you're in that room (Interview Participant 12).  
28

29 Sensitivity would probably be one of the---being able to read a room when you walk into  
30 it and kind of know what's going on or sense what's going on there and be sensitive to  
31 the dynamics that you feel between people there (Interview Participant 1).  
32  
33

#### 34 Seeing the Patient as a Person

35  
36 In the context of clinical care, participants were emphatic about the importance of  
37 *extending one's vision beyond the illness, the body, and 'the patient' in order to view the person*  
38 *as a fellow human.* Seeing the patient as a person ranged from simple gestures such as asking the  
39  
40 person how they preferred to be addressed, to eliciting the person's story, to allowing the person  
41  
42 to make care decisions versus telling them what to do.  
43  
44  
45  
46  
47

48 I think what we need to do is we need to see this person as a human being... treat this  
49 person as a human being and not as the patient with diagnosis X, but as a person who has  
50 had all of these lived experiences that is at this place and is feeling this way (Interview  
51 Participant 8).  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 So, you need to look them in the eyes and be soft and kind and like 'I see you behind  
4 there'. And I'm going to take care of you, like I've got you, like I got this (Interview  
5 Participant 15).  
6

7  
8 I think true compassion is you know an understanding individually of what is it that  
9 person wants and needs from us that we can give to them? (Interview Participant 2).  
10

## 11 Accepting The Person Where They Are At 12

13 Participants described a third theme that involved *seeking to understand the person's*  
14 *circumstance and accept them unconditionally in spite of their past and/or present behaviours.*  
15

16 This primarily involved accepting patient attitudes, behaviours, and frustrations that were related  
17 to their situation. Extending unconditional acceptance toward abusive patients or individuals  
18 with a checkered past served as both the greatest challenges to compassion and case exemplars  
19 of their compassionate colleagues.  
20  
21  
22  
23  
24  
25

26  
27 One of the nursing attendants told me one day how he had been with a patient for two  
28 days and this guy had been incontinent of stool and just messed himself again and he was  
29 unsteady and the nursing attendant was supporting the guy and cleaning him up and while  
30 he was back there cleaning the back of his legs his bowels let go again and this  
31 professional, without complaint, began to wash the guy again. And the man turned  
32 around and using a racial epithet cursed him, what are you doing back there you fuck, and  
33 again the man took it with humility and generosity of spirit and didn't strike back with  
34 words or actions but fulfilled his duty. That's a striking story of compassion (Stage 1  
35 Focus Group Participant 4).  
36  
37

38  
39 We've had a holocaust survivor. We've had a German soldier you know, who was  
40 forced into doing things that they didn't want to do.... We have to have compassion all  
41 around for each person (Interview Participant 2).  
42

43 One example that comes to mind is a young woman, who was a prostitute...and I was  
44 working in the OR and people were talking over her in a very disparaging manner...and I  
45 remember my thought at the time was I don't think she thought as a little girl 'Gee, I'd  
46 like to be a prostitute when I grow up'. But stuff happened in her life that that's where  
47 she was (Stage 3 Focus Group Participant 3).  
48  
49

## 50 **Forging a Healing Alliance** 51

52 Although participants felt that compassion did not require a pre-existing relationship,  
53 they nonetheless felt that compassion was further forged and optimized through the  
54  
55  
56  
57  
58  
59

1  
2  
3 establishment of a therapeutic relationship-- *a relationship that is nurtured that is cultivated*  
4  
5 *through verbal and non-verbal communication that promotes healing through an in-depth*  
6  
7 *understanding of the person and their unique experiences in order to personalize compassionate*  
8  
9 *care.* Four interrelated themes comprised the category of Forging a Healing Alliance: being  
10  
11 present; relational communication; therapeutic relationship; and in-depth understanding of the  
12  
13 person.  
14  
15

#### 16 17 Being Present: Demeanor

18  
19 While time was a factor in forging a healing alliance, participants also felt that it could be  
20  
21 quickly established through the demeanor HCPs conveyed within each clinical encounter  
22  
23 regardless of its duration. According to several participants, demeanor involved attempting to be  
24  
25 fully present to the patient and was reflected in the way in which care is given—whereby their  
26  
27 demeanor enriched each care interaction.  
28  
29

30  
31 Because it's not what you do, it's the way you do things for people that is compassion  
32  
33 (Stage 1 Focus Group Participant 35).

34  
35 She's [exemplary compassionate care nominee] fully present in every room and when  
36  
37 caring for someone, she makes it seem like they're the only person she has to take care of  
38  
39 (Stage 1 Focus Group Participant 24).

40  
41 He [nominee] provides comfort with his calm and gentle demeanor (Stage 1 Focus Group  
42  
43 Participant 15).

#### 44 45 Relational Communication

46  
47 Relational communication was described as *the establishment of a deeper understanding*  
48  
49 *of the person and their individualized needs through active listening.* The centrality of listening  
50  
51 relative to compassion involved listening to what patients said, but also listening to the subtext of  
52  
53 what wasn't being said— tone of voice, moments of silence, and non-verbal cues that helped to  
54  
55 unmask hidden suffering.  
56  
57  
58  
59

1  
2  
3 I think when people feel heard and they feel like someone actually cares and actually is  
4 taking the time to listen that's what they interpret as being compassionate (Interview  
5 Participant 7).  
6

7  
8 When they call I usually just drop everything and you listen to their tone of voice. I can  
9 hear it when the tears are there you know... there's that pause and I let that pause happen  
10 because they're deciding whether or not they're going to tell me or they're realizing how  
11 overwhelmed they really are (Interview Participant 13).  
12

13  
14 It's listening to what's not being said and recognizing that and really gently making it  
15 okay to talk about those things (Interview Participant 15).  
16

### 17 Therapeutic Relationship

18  
19 The themes of being present and relational communication were instrumental in  
20 establishing a deeper therapeutic relationship which participants described as *a human-to-human*  
21 *connection facilitated through the mutual sharing of stories, feelings, and expressions of care*  
22 *between healthcare providers and their patients in order to promote healing.* Establishing a  
23  
24 therapeutic relationship extended the largely unidirectional theme of 'Seeing the Patient as a  
25  
26 Person' to a reciprocal level, whereby participants related to their patients from a place of shared  
27  
28 humanity.  
29  
30  
31  
32  
33

34  
35 He [physician nominee] tries to find out who they are and makes time for social visits not  
36 just medical assessments (Stage 1 Focus Group Participant 29).  
37

38  
39 I really wanted to understand, but not from a head space, like from a heart space in terms  
40 of the feeling and really kind of connecting that way with her (Interview Participant 15).  
41

42  
43 I try to have a sense of what story they're living and be able to kind of feel how I can be a  
44 constructive player in that story (Interview Participant 1).  
45

### 46 In-Depth Understanding of the Person

47  
48 The end outcome within the category of forging a healing alliance was to come to an in-  
49  
50 depth understanding of the person, allowing HCPs to address a person's multifactorial needs in a  
51  
52 personalized manner. Coming to an in-depth understanding of the person was conceptualized as  
53  
54  
55  
56  
57  
58  
59

1  
2  
3 *a deep desire to engross oneself in a person's story in order to determine sources of personal*  
4 *meaning and how these were effected by and contributed to their suffering.* Whereas the theme of  
5  
6  
7 'Intention' involved emotional resonance (feeling with), in which participants considered how  
8 they would want to be treated if they were in the patient's position, an in-depth understanding  
9  
10 engaged a higher process of 'feeling for' the patient. This involved moving beyond considering  
11  
12 how the HCP would want to be treated if they were the patient, to in having developed an in-  
13  
14 depth understanding of the person--an understanding of how the patient would want to be  
15  
16  
17  
18  
19 treated.

20  
21 The Golden Rule is good to a point, but sometimes somebody else might not want what I  
22 want (Interview Participant 15).

23  
24  
25 What brings meaning to them and it's about how we engage and being able to support  
26 that (Stage 1 Focus Group Participant 30).

### 27 28 **Ameliorating Suffering**

29  
30  
31 The primacy of action within each of the categories of compassion culminated in  
32 participants identifying 'ameliorating suffering' as the ultimate goal of compassion.

33  
34 Ameliorating suffering was defined as *tangible acts intended to alleviate actual or anticipatory*  
35  
36  
37 *threats to a person's physical, emotional, social and/or spiritual wellbeing.*

### 38 39 40 **Discerning Needs**

41  
42 The Theme of Discerning Needs describes *the ability to anticipate, perceive or prioritize*  
43  
44 *health care needs based on knowledge of the person and their circumstance in order to alleviate*  
45  
46  
47 *their suffering.* Discernment ranged from anticipating an impending pain crisis, to recognizing  
48  
49 the patient's need for personal space, preparing the patient for a prognostic conversation,  
50  
51 demoting competing system priorities, and prioritizing which patients needed compassion the  
52  
53  
54 most.



1  
2  
3 One of the strategies that I usually employ is I try to think about at the beginning of the  
4 day, you know who needs the most time today? And then structure my day accordingly  
5 as much as possible... (Interview Participant 9).  
6

7  
8 The discerning needs piece really resonated with me, thinking back to my days as a  
9 bedside palliative care nurse....it's absolutely true, especially discerning which patients  
10 need more compassion (Stage 3 Focus Group Participant 5).  
11

12 Then that's where anticipatory care is really important, because you're like I've already  
13 thought of that. That's why I just gave him a break-through because he's looking like he  
14 was in pain and he has to go to radiation in half an hour, so follow along (Interview  
15 Participant 4).  
16  
17

### 18 Providing Emotional and Existential Support 19

20 While compassion traversed the care trajectory, health domains and the caregiver/patient  
21 relationship, participants also identified key moments where compassion seemed to be essential  
22 or most needed--incidences of suffering that included emotional and existential distress.  
23  
24

25 Providing emotional and existential support involved *allaying uncertainty, fears, and distress*  
26 *that threaten personal existence by eliciting meaningful memories, affirming strengths, and*  
27 *providing supportive touch and words of affirmation.*  
28  
29  
30  
31  
32  
33

34 To me it didn't seem humane that this gentleman was gonna die alone, it just didn't seem  
35 right that he'd had no visitors and now he was gonna leave this world alone. I don't know  
36 if he knew I was there but I just held his hand and talked softly (Stage 1 Focus Group  
37 Participant 3).  
38  
39

40 I'm doing what I'm setting out to do and it's not only my job physically, but it's that  
41 bigger---maybe kind of total... but then there's a psychosocial, spiritual pain that they  
42 can be having (Interview Participant 11).  
43  
44

45 I think that we can have all the words and have all the nice clothes and look like we've  
46 very efficient, but I think it's compassion that shakes the hand of another person and that  
47 rubs their forehead, that opens the door to their heart where they feel safe (Interview  
48 Participant 6).  
49

### 50 Addressing Needs 51

52 The final theme, addressing needs, involved *a proactive and attuned response to directly*  
53 *engage in and alleviate a person's multifactorial suffering.* Participants expressed that  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 compassion addressed needs primarily in two ways: small acts of compassion within HCPs' call  
4 of duty; and extraordinary acts beyond the call of duty. There were several specific examples of  
5  
6 small acts of compassion identified. They included exercising diligence and sensitivity in routine  
7  
8 care such as attending to activities of daily living; and demonstrating attention to detail in  
9  
10 seemingly perfunctory activities such as filling out a patient's paperwork or conveying patient  
11  
12 preferences at shift change. Addressing needs that fell outside of the call of duty or 'going the  
13  
14 extra mile' were arguably the greatest indicators of a compassionate HCP and were the most  
15  
16 frequently stated reason for peers to nominate their exemplary colleagues. In many ways, these  
17  
18 extraordinary acts seemed to function as a litmus test to detect whether care was internally  
19  
20 motivated from a place of virtues or an ulterior motivator such as remuneration, duty, or social  
21  
22 desirability.  
23  
24  
25  
26  
27  
28

29  
30 I think that empathy is really understanding the feeling and perspective kind of or what is  
31  
32 happening for that person. I think the compassion is taking that and translating it into an  
33  
34 actionable item (Interview Participant 15).

35  
36 And the little things too, when people are in bed we ask them if they like ice water or  
37  
38 room temperature water and it seems like a pretty minor thing but if you don't really like  
39  
40 ice water and you have a jug of it at your bedside and that's all you have to drink that's  
41  
42 not really compassion (Stage 1 Focus Group Participant 8).

43  
44 It's making sure that their paperwork is done and their paperwork is sent out and  
45  
46 following up on things that maybe got dropped along the way... There's compassion in  
47  
48 that too, because you want to make sure that the road is paved as smoothly for that family  
49  
50 and that patient as possible (Interview Participant 13).

51  
52 They stop at the cafe to get a bowl of soup that they know that that patient likes that bowl  
53  
54 of soup. It has nothing to do with their job but they know that they're not eating and if  
55  
56 they hear them say something that they like, they stop and pick it up....and they sit and  
57  
58 eat with them (Stage 1 Focus Group Participant 29).  
59

## 60 **DISCUSSION**

1  
2  
3           Compassion is widely regarded as an essential part of quality healthcare. In contrast, the  
4  
5 construct is still at an early stage of research development, with limited clinical studies  
6  
7 describing how aspects of compassion can be operationalized in practice. The HCP Compassion  
8  
9 Model delineates the key dimensions of this dynamic construct and begins to address this theory-  
10  
11 practice gap. We hope it will foster discussion as a pragmatic tool for evidence informed practice  
12  
13 and as an empirical foundation for future studies in this area.  
14  
15

16  
17           This study conceptualized compassion within healthcare from the perspective of HCPs,  
18  
19 extending our previous research on patients' perspectives<sup>19</sup>. While we had anticipated that the  
20  
21 HCP Compassion Model would be depicted in a distinct fashion to the Patient Compassion  
22  
23 Model,<sup>19</sup> our analysis revealed that while there were some differences at a thematic level, the  
24  
25 core categories largely mirror the Patient Compassion Model—illustrating the flipside of the  
26  
27 compassion dyad (Figure 2). This was further verified by Stage 3 participants, who provided face  
28  
29 validity as they endorsed the structure and temporal flow of the model. The model parallels the  
30  
31 sequential clinical process of a HCP approaching the bedside, making an initial relational  
32  
33 connection, getting to know the person, forging a therapeutic alliance, and then working to  
34  
35 ameliorate suffering. While the model depicts a sequential flow of compassion between and  
36  
37 within categories, Stage 3 participants cautioned against a strict stepwise conceptualization of  
38  
39 compassion, noting that in reality there was oscillation across the model. In practice, this  
40  
41 suggests that HCPs can revisit earlier themes within the model. For example, they likely reassess  
42  
43 their intentions on an ongoing basis at each clinical interaction or come to a deeper acceptance of  
44  
45 the person as the therapeutic relationship is strengthened. Likewise, while participants felt that  
46  
47 each of the categories needed to be engaged for care to be considered compassionate, the three  
48  
49 intertwined categories within the model's core illustrate that certain dimensions of compassion  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 may be more prominent to others, while still reaching the same ultimate outcome--addressing a  
4 person's needs. For example, coming to know a person may be more prominent in admitting a  
5 stable patient to a care home, whereas ameliorating suffering will likely be more prominent when  
6 treating a patient with an acute pain crisis. These 5 dimensions depicted within the model are  
7 congruent with previous research which identified compassion as a multi-dimensional construct  
8 consisting of clinical behaviours, communication skills, presence, understanding and emotional  
9 engagement.<sup>13</sup> The current study extends this previous research by providing greater detail about  
10 the contents of these dimensions through the 13 themes contained within them, while also adding  
11 the Virtuous Intent dimension, identifying the pivotal role that virtues play in engendering a  
12 compassionate response within HCPs.  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

26 A multidimensional understanding of compassion adds depth to current constructs of  
27 compassion both at the bedside and in research. Much of the previous work has focused on  
28 unidimensional conceptualizations of compassion limiting it to a feeling, a trait, or a virtue,  
29 producing corollary interventions to improve HCP affective components of compassion through  
30 contemplative practices and mindfulness training.<sup>9 44-46</sup> Inarguably, interventions aimed at  
31 enhancing awareness of HCP attitudes and cultivating virtues of love, kindness, altruism, and  
32 equanimity, are essential to improve compassionate care. The current work offers the opportunity  
33 to augment these with training focused on clinical skills and behaviours reflecting the  
34 interdependent categories and themes on which compassionate care is grounded.  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46

47 HCP participants provided insight into the internalized processes of compassion, which  
48 patients in our previous study could only postulate due to their limited perspective as the  
49 recipients of compassionate care. At a categorical level these new findings resulted in the  
50 emergence of the broader category of 'Forging a Healing Alliance', with 'Relational  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 Communication' being subsumed as a theme within it. The additional theme of 'Therapeutic  
4 Relationship', along with the themes Demeanor and Relational Communication, emphasize  
5  
6 HCPs' intent and the centrality of coming to an in-depth understanding of the patient as a person  
7  
8 in compassion, affirming similar research in the field of psychology.<sup>20 47</sup>  
9

10  
11  
12 A more fulsome understanding of compassion at a thematic level emerged from this  
13  
14 study, as according to HCPs, compassion was not a systemic form of caring, but an intentional,  
15  
16 discerning and targeted modality. This affirms other researchers' work on the topic, who  
17  
18 reported that compassion is not coincidental but involves choice<sup>12 13 48 49</sup> and the down-regulation  
19  
20 of destructive HCP thoughts and behaviours.<sup>50</sup> Considering this prior and current research, we  
21  
22 suggest that compassion may be conceptualized through the lens of 'personalized healthcare',  
23  
24 extending the concept of personalized medicine that focuses on tailoring the treatment of disease  
25  
26 based on individual characteristics,<sup>51</sup> to each interaction the patient has with their HCPs.  
27  
28  
29

30  
31 The themes of 'Discerning needs' and 'Intention' raise additional questions regarding the  
32  
33 unconditional nature of compassion. Previous research identified compassion as largely being an  
34  
35 unconditional care construct, in comparison to the conditional nature of sympathy, which is  
36  
37 mediated by the self-preservation of the caregiver, and empathy, which is effected by perceived  
38  
39 relatedness and deservedness.<sup>39 52 53</sup> According to HCPs, compassion involved bringing an open  
40  
41 mind and not simply an empty head to each patient encounter,<sup>31 54</sup> echoing Wilber's summation  
42  
43 that, "real compassion includes wisdom and so it makes judgments of care and concern".<sup>55</sup>  
44  
45  
46 Results from the current study suggest that reasoning, as it relates to compassion, assesses  
47  
48 individuals' needs and seeks to understand the person, in contrast to other care constructs that  
49  
50 seem to focus more on assessing the individual and allowing this to determine how to act  
51  
52 accordingly. In a similar vein, participants' identification that compassion involved choice, is  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 further evidence that while compassion involves cognitive processing, it is not selective. Rather,  
4 the practice of intentionality involved exposing and counteracting these subconscious conditions  
5 and barriers in order to accept the person in an unconditional manner—expanding ones' capacity  
6 for compassion in the process.  
7  
8  
9  
10

11  
12 One of the surprising findings of this study was the identification of virtues, the good and  
13 noble qualities embedded within the character of HCPs, as the primary motivator of  
14 compassion—unexpectedly replicating the results of our patient study.<sup>19</sup> Several HCPs went so  
15 far as to describe compassion as a process of self/provider congruence, whereby they attempted  
16 to integrate and cultivate their virtues into their professional practice.<sup>56</sup> Leaders in healthcare  
17 practice, policy and education might appropriately ask, can compassion be mandated, learned  
18 and evaluated at the bedside? The current study suggests that this remains a challenging and  
19 controversial proposition as genuine compassion involves the personal qualities of HCP and  
20 extraordinary acts that go beyond standard practice, job expectations or routine care. While  
21 making healthcare more compassionate is a pressing need, doing so by requiring HCPs to act in a  
22 way that is perceived by patients as compassionate is not only disingenuous and antithetical to  
23 compassion, but leads to a standardized approach that denudes HCPs of personal expression and  
24 the opportunity to demonstrate care beyond what is expected.<sup>2 3 6-8</sup>  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41

### 42 **Strengths and Limitations**

43

44 This study has several strengths and limitations. Prior work in this field has broadly  
45 considered physician, patient and family, clinical situation, and environmental factors which  
46 individually and transactionally contribute to compassion.<sup>14 15</sup> The current study seeks to expand  
47 on this work, by delineating elements which are at the root of these factors, across a range of  
48 training backgrounds of physicians, other health care providers, and support staff involved in the  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 delivery of healthcare. This study also assesses the interdependence of these elements building  
4  
5 on research describing dimensions of compassion based on the direct reports of nurses caring for  
6  
7 older people with a chronic disease.<sup>12 13</sup> The current study adds to this knowledge base in its  
8  
9 interdisciplinary focus, inclusion of urban and rural populations, recruiting from multiple types  
10  
11 of care settings, and the identification of the virtuous intent dimension, demonstrating that  
12  
13 compassionate communication and action is informed and regulated by certain HCP qualities.  
14  
15

16  
17 We recruited participants from a palliative care program in order to study compassion.  
18  
19 We recognize that while compassion is deemed an essential element of healthcare, and is central  
20  
21 to the professional motivation of the majority of healthcare providers, it is inarguably of great  
22  
23 relevance in a healthcare environment which provides care where suffering is prevalent. We  
24  
25 reasoned that while team members in a Palliative Care setting do not have a monopoly on  
26  
27 compassion, they share with other healthcare providers across other healthcare settings, a deep  
28  
29 professional respect for its relevance and importance.  
30  
31

32  
33 This begs the question--Are the findings from this study generalizable to other healthcare  
34  
35 settings? Palliative care is by nature a team based environment, and each professional group  
36  
37 within it contributes to the overall culture of care. Dissecting out the perspectives of specific  
38  
39 healthcare professional groups within the team as being distinct from the team itself may  
40  
41 ultimately be identified as a worthwhile approach to better understanding barriers and facilitators  
42  
43 to compassion, but at present requires further research. It is known that physician barriers to  
44  
45 compassion are different based on number of years of clinical experience and different medical  
46  
47 specialties.<sup>14 15</sup> We therefore reasoned that it was wise to first establish what is common,  
48  
49 establishing the empirical foundation of the construct, allowing future studies to further validate  
50  
51 its generalizability and transferability to other settings and specialties.  
52  
53  
54  
55  
56  
57  
58  
59

1  
2  
3 Further, while the snowball sampling technique of Stage 1 participants nominating Stage  
4 2 interviewees was beneficial, it may have diminished the heterogeneity of the sample, as  
5 participants may have inadvertently nominated like-minded individuals. Similarly, the HCPs  
6 sampled in this study were predominately nurses and physicians. While reflecting the  
7 composition of an interdisciplinary team and being representative of the professional  
8 composition of healthcare as whole, it may not adequately represent the views of other groups of  
9 professionals. Finally, while participants identified behaviours that were associated with  
10 compassion, these were not verified by observational data.

### 21 **Implications for Research, Policy and Clinical Practice**

22  
23  
24 The HCP Compassion Model provides a foundation that defines compassion in  
25 healthcare and its provision at the bedside. It may lead to the development of clinical tools to  
26 cultivate the requisite knowledge, skills, behaviours, and qualities to enhance compassionate care  
27 to others. For example, it could potentially inform the development of a patient reported  
28 compassion measure or serve as a blueprint to develop targeted and evidence informed  
29 educational interventions for healthcare systems aiming to enhance patients experiences of  
30 compassion specifically.<sup>17</sup>

### 39 **Conclusions**

40  
41  
42 This study provides HCPs, educators, researchers and policy makers with a multi-  
43 dimensional model of compassion. It identifies the knowledge, skills, behaviours and qualities  
44 which underpin delivery of compassionate health care at the bedside. The systematic nature of  
45 the HCP Compassion Model characterizes the components of compassion and their  
46 interrelatedness. There is also an element of flexibility within these domains that recognizes that  
47 true compassion comes from within the person, through a dynamic human interaction with a  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 patient and the patient's needs. While mastery may be unattainable, the multidimensional facets  
4  
5 of compassion can potentially be nurtured in individual health care providers and throughout the  
6  
7 cultures they work within.  
8  
9

## 12 **Disclosures and Acknowledgements**

14 Contributors: All nine authors fulfill all four of the International Committee of Medical Journal  
15  
16 Editors guidelines for authorship. SS, SRB, TH, SM, KS, AS, NH and HMC conceptualized the  
17  
18 study. SS supervised PS who managed, acquired, cleaned and coordinated analysis of the data.  
19  
20  
21 SS, SRB, TH, SM, KS and PS analyzed interview and focus group data. All authors contributed  
22  
23 to the final draft and approved the final version for publication.  
24  
25

26 Acknowledgements: We would like to acknowledge and thank the MSI foundation for funding  
27  
28 this study and the University of Calgary University Relations who designed the Healthcare  
29  
30 Provider Compassion Model. We would like to acknowledge Kate Beamer, research assistant,  
31  
32 for her dedication and commitment to this study. We would also like to acknowledge and thank  
33  
34 the research participants who generously shared their time, wisdom, experiences and enthusiasm  
35  
36 on the topic.  
37  
38

39  
40 Data Sharing Statement: No additional data are available  
41

42 Funding Statement: This study was supported by a MSI Foundation Grant, (Grant #880).  
43

44 Competing Interest Statement: The authors declare no conflicts of interest.  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



## References:

1. American Medical Association. Code of medical ethics 2006 [Available from: <https://www.ama-assn.org/about-us/code-medical-ethics> accessed 23 February 2017.
2. Department of Health. Confidence in caring: A framework for best practice. 2008 [Available from: [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086387?IdcService=GET\\_FILE&dID=144574&Rendition=Web](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086387?IdcService=GET_FILE&dID=144574&Rendition=Web) accessed August 4 2017.
3. Flocke SA, Miller WL, Crabtree BF. Relationships between physician practice style, patient satisfaction, and attributes of primary care. *J Fam Pract* 2002;51(10):835-40.
4. Paterson R. Can we mandate compassion? *Hastings Center Report*;41(2):20-3.
5. MacLean L. The Vale of Leven Hospital Inquiry Report 2014 [Available from: <http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf> accessed May 2 2017.
6. The Willis Commission. Quality with compassion: the future of nursing education. Report of the Willis Commission on Nursing Education 2012 [Available from: <https://www.nursingtimes.net/download?ac=1255026> accessed May 2 2017.
7. Department of Health. More care, less pathway- A review of the Liverpool care pathway 2013 [Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212450/Liverpool\\_Care\\_Pathway.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf) accessed May 2 2017.
8. Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry The Stationary Office: London, England; 2013 [updated 2013//. Available from: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry> accessed August 4 2017.
9. Sinclair S, Norris JM, McConnell SJ, et al. Compassion: a scoping review of the healthcare literature. *BMC Palliat Care* 2016;15:6. doi: 10.1186/s12904-016-0080-0
10. Papadopoulos I, Zorba A, Koulouglioti C, et al. International study on nurses' views and experiences of compassion. *Int Nurs Rev* 2016;63(3):395-405. doi: 10.1111/inr.12298
11. Papadopoulos I, Taylor G, Ali S, et al. Exploring Nurses' Meaning and Experiences of Compassion: An International Online Survey Involving 15 Countries. *J Transcult Nurs* 2015 doi: 10.1177/1043659615624740
12. Van Der Cingel M. Compassion and professional care: exploring the domain. *Nurs Philos* 2009;10(2):124-36. doi: 10.1111/j.1466-769X.2009.00397.x
13. Van Der Cingel M. Compassion in care: a qualitative study of older people with a chronic disease and nurses. *Nurs Ethics* 2011;18(5):672-85. doi: 10.1177/0969733011403556
14. Fernando AT, 3rd, Consedine NS. Beyond compassion fatigue: the transactional model of physician compassion. *J Pain Symptom Manage* 2014;48(2):289-98. doi: 10.1016/j.jpainsymman.2013.09.014
15. Fernando AT, 3rd, Consedine NS. Barriers to Medical Compassion as a Function of Experience and Specialization: Psychiatry, Pediatrics, Internal Medicine, Surgery, and General Practice. *J Pain Symptom Manage* 2017 doi: 10.1016/j.jpainsymman.2016.12.324
16. Streiner DL, Norman GR, Cairney J. Health measurement scales : a practical guide to their development and use. Fifth edition. ed. Oxford: Oxford University Press 2015.

17. Sinclair S, Russell LB, Hack TF, et al. Measuring Compassion in Healthcare: A Comprehensive and Critical Review. *The Patient: Patient Centred Outcomes Research* 2016 doi: 10.1007/s40271-016-0209-5
18. Beattie M, Murphy DJ, Atherton I, et al. Instruments to measure patient experience of healthcare quality in hospitals: a systematic review. *Syst Rev* 2015;4:97. doi: 10.1186/s13643-015-0089-0
19. Sinclair S, McClement S, Raffin-Bouchal S, et al. Compassion in Health Care: An Empirical Model. *J Pain Symptom Manage* 2016;51(2):193-203. doi: 10.1016/j.jpainsymman.2015.10.009
20. Vivino BL, Thompson BJ, Hill CE, et al. Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research* 2009;19(2):157-71.
21. Way D, Tracy SJ. Conceptualizing compassion as recognizing, relating and (re) acting: A qualitative study of compassionate communication at hospice. *ComM* 2012;79
22. Ghaljeh M, Iranmanesh S, Nayeri ND, et al. Compassion and care at the end of life: oncology nurses' experiences in South-East Iran. *International Journal of Palliative Nursing*;22(12):588-97.
23. Lown BA, Rosen J, Marttila J. An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health Aff (Millwood)* 2011;30 doi: 10.1377/hlthaff.2011.0539
24. Graber DR, Mitcham MD. Compassionate clinicians: take patient care beyond the ordinary. *Holist Nurs Pract* 2004;18(2):87-94.
25. Kvangarsnes M, Torheim H, Hole T, et al. Nurses' perspectives on compassionate care for patients with exacerbated chronic obstructive pulmonary disease. *J Allergy Ther* 2013;4 doi: 10.4172/2155-6121.1000158
26. Lloyd M, Carson A. Making compassion count: Equal recognition and authentic involvement in mental health care. *Int J Consumer Stud* 2011;35 doi: 10.1111/j.1470-6431.2011.01018.x
27. Bray L, O'Brien MR, Kirton J, et al. The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students. *Nurse Educ Today* 2014;34 doi: 10.1016/j.nedt.2013.06.017
28. Armstrong AE, Parsons S, Barker PJ. An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study. *J Psychiatr Ment Health Nurs* 2000;7(4):297-305.
29. Skaff KO, Toumey CP, Rapp D, et al. Measuring compassion in physician assistants. *JAAPA* 2003;16
30. Horsburgh D, Ross J. Care and compassion: the experiences of newly qualified staff nurses. *J Clin Nurs* 2013;22(7-8):1124-32. doi: 10.1111/jocn.12141
31. Department of Health. Compassion in Practice. Nursing, Midwifery and Care Staff. Our Vision and Strategy 2012 [Available from: <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> accessed May 2 2017.
32. Kneafsey R, Brown S, Sein K, et al. A qualitative study of key stakeholders' perspectives on compassion in healthcare and the development of a framework for compassionate interpersonal relations. *J Clin Nurs* 2016;25(1-2):70-9. doi: 10.1111/jocn.12964
33. McCaffrey G, McConnell S. Compassion: a critical review of peer-reviewed nursing literature. *J Clin Nurs* 2015;24(19-20):3006-15. doi: 10.1111/jocn.12924

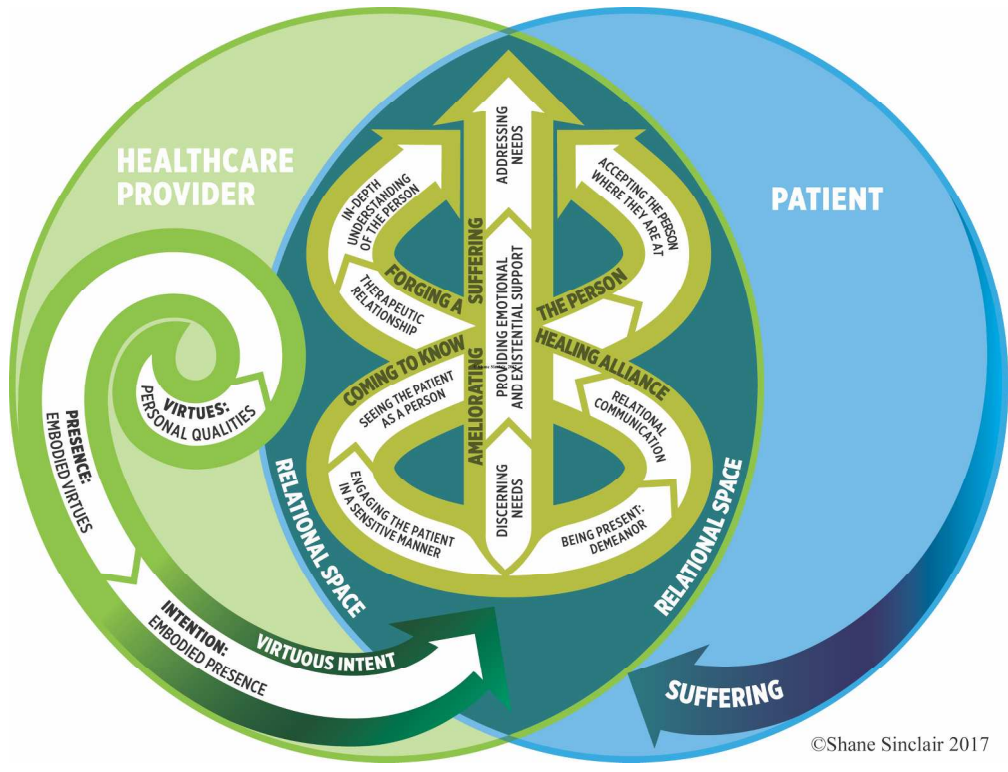
- 1
- 2
- 3
- 4 34. Perez-Bret E, Altisent R, Rocafort J. Definition of compassion in healthcare: a systematic
- 5 literature review. *Int J Palliat Nurs* 2016;22(12):599-606. doi:
- 6 10.12968/ijpn.2016.22.12.599
- 7
- 8 35. R. F. Report of the Mid Staffordshire NHS Foundation Trust public inquiry. *London: The*
- 9 *Stationary office* 2013
- 10
- 11 36. Callwood A, Cooke D, Allan H. Developing and piloting the multiple mini-interview in pre-
- 12 registration student midwife selection in a UK setting. *Nurse Educ Today*
- 13 2014;34(12):1450-4. doi: 10.1016/j.nedt.2014.04.023
- 14
- 15 37. Willis L. Raising the Bar. Shape of Caring: A Review of the Future Education and Training
- 16 of Registered Nurses and Care Assistants 2015 [accessed May 2 2017].
- 17
- 18 38. Strauss AL, Corbin JM. Basics of qualitative research : grounded theory procedures and
- 19 techniques. Newbury Park, Calif.: Sage Publications 1990.
- 20
- 21 39. Sinclair S, Beamer K, Hack TF, et al. Sympathy, empathy, and compassion: A grounded
- 22 theory study of palliative care patients' understandings, experiences, and preferences.
- 23 *Palliat Med* 2017;31(5):437-47. doi: 10.1177/0269216316663499
- 24
- 25 40. Sinclair S, Torres MB, Raffin-Bouchal S, et al. Compassion training in healthcare: what are
- 26 patients' perspectives on training healthcare providers? *BMC Med Educ* 2016;16:169. doi:
- 27 10.1186/s12909-016-0695-0
- 28
- 29 41. Glaser BG, Strauss AL. The discovery of grounded theory; strategies for qualitative research.
- 30 Chicago: Aldine Pub. Co. 1967.
- 31
- 32 42. Corbin JM, Strauss AL. Basics of qualitative research: techniques and procedures for
- 33 developing grounded theory. Fourth edition. ed. Los Angeles: SAGE 2015.
- 34
- 35 43. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research
- 36 (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*
- 37 2007;19(6):349-57. doi: 10.1093/intqhc/mzm042
- 38
- 39 44. Gilbert P. The origins and nature of compassion focused therapy. *Br J Clin Psychol*
- 40 2014;53(1):6-41. doi: 10.1111/bjc.12043
- 41
- 42 45. Jazaieri H, Jinpa GT, McGonigal K, et al. Enhancing compassion: A randomized controlled
- 43 trial of a compassion cultivation training program. *Journal of Happiness Studies*
- 44 2013;14(4):pp. doi: 10.1007/s10902-012-9373-z
- 45
- 46 46. Seppala EM, Hutcherson CA, Nguyen DT, et al. Loving-kindness meditation: a tool to
- 47 improve healthcare provider compassion, resilience, and patient care. *Journal of*
- 48 *Compassionate Health Care* 2014;1(1):5. doi: 10.1186/s40639-014-0005-9
- 49
- 50 47. Gilbert P. The origins and nature of compassion focused therapy. *Br J Clin Psychol* 2014;53
- 51 doi: 10.1111/bjc.12043
- 52
- 53 48. van der Cingel M. Compassion: the missing link in quality of care. *Nurse Educ Today*
- 54 2014;34(9):1253-7. doi: 10.1016/j.nedt.2014.04.003
- 55
- 56 49. Zamanzadeh V, Valizadeh L, Rahmani A, et al. Factors facilitating nurses to deliver
- 57 compassionate care: a qualitative study. *Scand J Caring Sci* 2017 doi: 10.1111/scs.12434
- 58
- 59 50. Halifax J. A heuristic model of enactive compassion. *Curr Opin Support Palliat Care*
- 60 2012;6(2):228-35. doi: 10.1097/SPC.0b013e3283530fbc
- 51
- 52 51. Smith R. Stratified, personalised, or precision medicine. *The BMJ Opinion* 2012
- 53
- 54 52. Singer T, Klimecki OM. Empathy and compassion. *Curr Biol* 2014;24(18):R875-8. doi:
- 55 10.1016/j.cub.2014.06.054
- 56
- 57
- 58
- 59
- 60

- 1  
2  
3 53. Post SG, Ng LE, Fischel JE, et al. Routine, empathic and compassionate patient care:  
4 definitions, development, obstacles, education and beneficiaries. *J Eval Clin Pract*  
5 2014;20(6):872-80. doi: 10.1111/jep.12243  
6  
7 54. Bloom P. *Against Empathy: The Case for Rational Compassion*: Harper Collins: New York  
8 2016.  
9 55. Wilber K. *One Taste: Daily Reflections on Integral Spirituality*: Shambhala Publications  
10 2000.  
11 56. Rogers CR. *A Theory of Therapy, Personality, and Interpersonal Relationships: As*  
12 *Developed in the Client-centered Framework*: New York, NY: McGraw-Hill 1959.  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

Category	Theme
Virtuous Intent	Virtues: Personal Qualities
	Presence: Embodied Virtues
	Intention: Embodied Presence
Relational Space	
Coming to Know The Person	Engaging the Patient in a Sensitive Manner
	Seeing the Patient as a Person
	Accepting The Person Where They Are At
Forging a Healing Alliance	Being Present: Demeanor
	Relational Communication
	Therapeutic Relationship
	In-Depth Understanding of the Person
Ameliorating Suffering	Discerning Needs
	Providing Emotional and Existential Support
	Addressing Needs

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



©Shane Sinclair 2017

208x157mm (300 x 300 DPI)

view only



**Table 1**

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
<b>Domain 1: Research team and reflexivity</b>		
Personal Characteristics		
1.	Interviewer/facilitator or	Which author/s conducted the interview or focus group? <i>The corresponding author (SS) and a research assistant</i> <b>Pg. 9</b>
2.	Credentials	What were the researcher's credentials? (E.g. PhD, MD) <i>. The research team consisted of 7 PhD trained researchers (SS, TH, SM, SRB, KS, HMC, PS) (5 of whom were experts in qualitative methods (SS, TH, SM, SRB, KS) ); 2 palliative care MD (NH, AS)</i> <b>Pg. 13</b>
3.	Occupation	What was their occupation at the time of the study? <i>All of the research team had academic appointments, while one researcher (AS) also had a clinical position working on a palliative care unit in Alberta Health Services.</i> <b>Pg. 1, pg 13</b>
4.	Gender	Was the researcher male or female? <i>The research assistant was a female. The research team consisted of 6 males, and 3 females.</i> <b>Pg. 1, pg. 13</b>
5.	Experience and training	What experience or training did the researcher have? <i>The research team has conducted a number of large qualitative studies utilizing grounded theory, ethnography and hermeneutics in addition to a track record conducting large multicenter trials.. The research assistant has considerable experience conducting qualitative interviews.</i> <b>Pg. 10, 13</b>
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement? <i>No</i> <b>Pg. 9</b>
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? (e.g. personal goals, reasons for doing the research) <i>No information was given to the participants about the</i>

researcher **Pg. 9**

8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? (e.g. <i>Bias, assumptions, reasons and interests in the research topic</i> ) <b>Pg. 9</b>
<b>Domain 2: study design</b>		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? (e.g. <i>grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i> ) <i>Grounded theory pg. 9&amp;13</i>
Participant selection		
10.	Sampling	How were participants selected? e.g. <i>purposive, convenience, consecutive, snowball</i> Participants were first informed about the study from through a education session and posters. <b>Pg. 6</b>
11.	Method of approach	How were participants approached? (e.g. <i>face-to-face, telephone, mail, email</i> ) <i>Convenience, snowball and theoretical sampling (Grounded Theory) were utilized. Pg. 6, 9</i>
12.	Sample size	How many participants were in the study? <i>A total of 57 participants participated in the study</i>
13.	Non-participation	How many people refused to participate or dropped out? Reasons? <i>None P. 9</i>
Setting		
14.	Setting of data collection	Where was the data collected? e.g. <i>home, clinic, workplace</i> <i>All data was collected in a private room at participants places of work (hospice, home care offices, hospital unit) P.9</i>
15.	Presence of non-participants	Was anyone else present besides the participants and researchers? <b>No p.9</b>
16.	Description of sample	What are the important characteristics of the sample? e.g. <i>demographic data, date</i> <i>The sample is largely representative of a interdisciplinary healthcare team. 86% were female. Average years in palliative care was 11.8 years. A cross-section of Nurses, Physicians and other members</i>



of the healthcare team are represented. **P.8 (table 1)**

Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested? <i>The interview followed an interview guide for each of the three stages. As it was semi-structured, probing questions were used when appropriate to delve more into an area of topical interest P.9, 10-12 (guides)</i>
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many? <i>No. However some of the Stage 2 interview participants who were nominated by stage 1 focus group members (Snowball sampling) also participated in the focus groups (n=3). Pg. 9</i>
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data? <i>All interviews were audio-recorded then given to a transcriptionist. All participants were made aware of the recording prior to signing the informed consent form pg.10</i>
20.	Field notes	Were field notes made during and/or after the interview or focus group? <i>The interviewer recorded field notes of non-verbal cues throughout the interview Pg. 10</i>
21.	Duration	What was the duration of the interviews or focus group? <i>Interviews lasted for 1 – 1 ½ hours pg. 9</i>
22.	Data saturation	Was data saturation discussed? <i>Yes. This was estimated during the design phase of the study, revisited after 25 interviews were conducted and reached after 7 focus groups (n=35) and 15 individual interviews. Pg. 7</i>
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction? <i>Transcripts were independently verified against the audio file by both the transcriptionist and the research assistant. When questions of clarification were needed about individual participants response the research assistant contacted the participant. As grounded theory is an iterative research method participant responses in the initial focus groups and interviews were followed up with subsequent participants as necessary. We also had a dedicated stage that involved member checking with a small sample of participants. Pg.10</i>

### Domain 3: analysis and findings

## Data analysis

24.	Number of data coders	How many data coders coded the data? The analysis team consisted of 5 coders (SS, TH, SM, SRB, KS) <b>Pg. 13</b>
25.	Description of the coding tree	Did authors provide a description of the coding tree? <i>No Straussian Grounded Theory doesn't use a coding tree. The authors did however provide a detailed account of the coding process including the use of a coding schema. <b>Pg. 13</b></i>
26.	Derivation of themes	Were themes identified in advance or derived from the data? <i>All themes were derived from the data <b>Pg. 13</b></i>
27.	Software	What software, if applicable, was used to manage the data? <i>No software was used for coding <b>N/A</b></i>
28.	Participant checking	Did participants provide feedback on the findings? <i>Yes, as mentioned above (#23), we contacted study participants directly to verify data as necessary. We also had an intentional member-checking focus group with a group of study participants related to the compassion model and to ensure that we had accurately represented their views (Stage 3). <b>Pg. 13</b></i>
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? (e.g. participant number) <i>Yes, participant quotation were use to support / illustrate the findings. All participants were referred to by a number to maintain participant anonymity <b>Pg. 15-25</b></i>
30.	Data and findings consistent	Was there consistency between the data presented and the findings? <i>Yes <b>Pg. 13-15</b></i>
31.	Clarity of major themes	Were major themes clearly presented in the findings? <i>Yes both major themes and subthemes were presented in the results <b>Pg. 15-25 and Figure 1 and 2</b></i>
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes? <i>Yes, all themes and subthemes were addressed and discussed <b>Pg. 13, 15-25, Figure 1 and 2</b></i>