Obstacles to compassion-giving among nursing and midwifery managers: an international study

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Aim: To explore nursing and midwifery managers' views regarding obstacles to compassion-giving across country cultures.

Background: The benefit of compassionate leadership is being advocated, but despite the fact that health care is invariably conducted within culturally diverse workplaces, the interconnection of culture, compassion and leadership is rarely addressed. Furthermore, evidence on how cultural factors hinder the expression of compassion among nursing and midwifery managers is lacking.

Methods: Cross-sectional, exploratory, international online survey involving 1 217 participants from 17 countries. Managers' responses on open-ended questions related to barriers for providing compassion were entered and thematically analysed through NVivo.

Results: Three key themes related to compassion-giving obstacles emerged across countries: 1. related to the managers' personal characteristics and experiences; 2. system-related; and 3. staff-related.

Conclusions: Obstacles to compassion-giving among managers vary across countries. An understanding of the variations across countries and cultures of what impedes compassion to flourish in health care is important.

Implications for nursing practice and policy: Nursing mangers should wisely use their power by adopting leadership styles that promote culturally competent and compassionate workplaces with respect for human rights. Policymakers should identify training and mentoring needs to enable the development of managers' practical wisdom. Appropriate national and international policies should facilitate the establishment of standards and guidelines for compassionate leadership, in the face of distorted organizational cultures and system-related obstacles to compassion-giving.

Introduction

Compassion is described as a core value in the Code of Ethics for Nurses of the International Council of Nurses (2012), and compassionate practices have been consistently associated with patient satisfaction (McClelland & Vogus 2014). The creation of a supportive working environment that cultivates compassion has been recognized as a substantial enabling factor for the practice of compassion, leading to the promotion of compassionate leadership in health care (West & Chowla 2017). Furthermore, a recent concept analysis of compassion in health care revealed that a crucial attribute of the concept is a humane response, whilst a person's cultural background is a key determinant for that response (Taylor et al. 2017). The adoption of compassionate leadership by nursing managers would seem as a natural event, nonetheless there is limited available evidence about the relationship of compassion to different leadership styles, and little is known about the leadership components that facilitate or hinder the promotion of compassion among nursing and midwifery managers. Finally, there is a dearth of national and international policies that introduce and promote compassionate leadership in health care.

Background

Research has shown that a person's culture influences their view and understanding of compassion. For example, in the study by Papadopoulos et al. (2016), nurses from the UK and the Philippines defined compassion mostly as 'empathy and kindness', whereas nurses from other countries, such as Colombia, viewed compassion as having 'a deep awareness of the suffering of others and a wish to alleviate it' (Papadopoulos et al. 2016, p. 399). A recent systematic review showed that cultural differences among patients and healthcare professionals impacted on the provision of compassion to ethnically diverse groups (Singh et al. 2018). The culturally implicit leadership theory (House et al. 2004) states that people develop specific ideas regarding the behaviours and attributes of a leader, which are based on their cultural background. Due to the interconnection of culture and compassion, Papadopoulos advocates for the practice of culturally competent compassion, a virtue which implies both a comprehension and a drive to act to reduce the pain of another human fellow, in accordance with the cultural background and the context of patients and carers 'the human quality of understanding the suffering of others and wanting to do something about it, using culturally appropriate and acceptable caring interventions, which take into consideration the patients' and the carers' cultural backgrounds as well as the context in which care is given' (Papadopoulos 2018, p. 2).

Among nurses, compassion is considered a core value integral to their caring role (Mannion 2014; Schofield 2016), and a recent concept analysis has emphasized the key constituents of compassionate midwifery (Ménage et al. 2017). A common theme in the literature is the essential presence of compassionate leaders in healthcare working environments (Ali & Terry 2017; Christiansen et al. 2015). West and colleagues (West et al. 2017) describe four key elements of compassionate leadership as: attending, understanding, empathising and helping. The role of the leader–manager in creating a supportive and compassionate environment has been discussed

in the past two decades (Jezuit 2002), but our knowledge of how nurse managers understand compassion, how they practice it and what may hinder them from providing it to their team members is limited. Also limited is our understanding of how cultural competence may facilitate or hamper leaders in the compassion-giving process. A study found that among 1 323 nurses who participated in an international survey about compassion (15 countries), only 4.3% of them reported that their managers were giving compassion to them (Papadopoulos et al. 2016). Another study explored barriers to compassion among nursing managers and found that key barriers were related to the managers' values and personality, the culture of the organization where they worked and the staff they worked with (Singh et al. 2018). Finally, a phenomenological study on the lived experiences of nurse executives found that personal and spiritual beliefs drove their practice of compassion and caring (Stepp 2019).

Despite the limited research evidence, it is safe to assume that obstacles to compassion vary depending on the country and culture of both managers and their staff. The present study focuses on nursing and midwifery managers from many different countries, and explores through their words what hinders them from enacting compassion. A nursing or midwifery manager is hereby defined as a leader of teams and individuals working in healthcare. In order to explore cultural differences and similarities, managers from different countries were recruited.

Aims of the study

The aim of this paper was to report on the perceived and declared obstacles to providing compassion as expressed by nursing and midwifery managers from around the world. The study also explores the role of culture and healthcare structures which were reported as obstacles to compassion-giving.

Methods

Research design

The design of the study was a cross-sectional, descriptive, exploratory online survey in which nursing and midwifery managers from 17 countries participated. Combining closed- and open-ended questions, the survey explored managers' views about compassion, but also their ideas on barriers, facilitators, advantages and the practical manifestations of a compassionate manager. In this paper, only responses to the open-ended questions related to barriers to compassion are analysed. The survey questions were pre-tested among members of the international team for potential issues with translation, and for improving questions' clarity and survey flow.

Data collection occurred between end of November 2017 and end of July 2018. The full survey can be accessed online (Papadopoulos, 2019).

The theoretical model of culturally competent compassion by Papadopoulos (2018) guided the present study. According to this model, compassion is in the centre of culturally competent practice and compassion in healthcare interactions cannot be understood without considering the cycle of 'cultural awareness, cultural knowledge, cultural sensitivity and cultural competence' (Papadopoulos 2018, p. 59).

The utilization of an online survey for data collection was considered as the most time-efficient and appropriate way to engage multiple countries around the world. It provided the opportunity to collect data in an inexpensive, anonymous and secure way (Wright 2005).

Data collection and participants

A snowball sampling method was used. International research partners circulated the invitation letter containing the link to the questionnaire to colleagues and people they knew who met the inclusion criteria which were (1) having a nursing/midwifery background and (2) having managerial responsibility for nurses or midwives in a hospital, community or educational setting. The data set of a country was included in the final study sample if a minimum of 40 participants completed the questionnaire. Data collection was conducted electronically using the web and supported by the software *Qualtrics*. The total number of participants was 1 217 across 17 countries. Table 1 provides an overview of the overall sample with key demographic information.

Ethical considerations

To invite participants, a letter was circulated which incorporated an information sheet and informed consent containing the study's details, ethical approval information, and a specification regarding the totally anonymous and voluntary participation. The study was approved by the Health and Social Care ethics sub-committee (No: 1 477) of the School of Health and Education at Middlesex University, UK. In addition, country co-researchers had to obtain ethical clearance from their universities or health care organization, where required.

Data analysis

An inductive thematic analysis was employed following the guidelines as described by Braun & Clarke (2006). This involved analysing the raw data line by line, and grouping them firstly into categories and consequently into themes.

Table 1 Key demographic variables of participants (*N* = 1217) from the 17 participating countries

Country	N	%	Gender	Years of management experience	Work Setting
1. Spain	124	10.2	F: 101	<10 yrs: 74	Hospital: 56
			M: 23	>10 yrs: 50	Non-hospital: 68
2. Slovakia	106	8.7	F: 102	<10 yrs: 88	Hospital: 75
			M: 4	>10 yrs: 18	Non-hospital: 31
3. Poland	95	7.8	F: 89	<10 yrs: 50	Hospital: 70
			M: 6	>10 yrs: 45	Non-hospital: 25
4. Israel	75	6.2	F: 69	<10 yrs: 35	Hospital: 35
			M: 6	>10 yrs: 40	Non-hospital: 40
5. Czech Republic	74	6.1	F: 73	<10 yrs: 35	Hospital: 74
			M: 1	>10 yrs: 39	
6.a Cyprus (Turkish speaking)	73	6.0	F: 73	<10 yrs: 34	Hospital: 72
				>10 yrs: 39	Non-hospital: 1
6.b Cyprus (Greek speaking)	47	3.9	F: 33	<10 yrs: 27	Hospital: 19
			M: 14	>10 yrs: 20	Non-hospital: 28
7. Chile	72	5.9	F: 69	<10 yrs: 44	Hospital: 23
			M: 3	>10 yrs: 28	Non-hospital: 49
8. Hungary	71	5.8	F: 5	<10 yrs: 38	Hospital: 60
			M: 64	>10 yrs: 33	Non-hospital: 11
			Other: 2		
9. Colombia	69	5.7	F: 62	<10 yrs: 40	Hospital: 36
			M: 7	>10 yrs: 29	Non-hospital: 33
10. Norway	63	5.2	F: 53	<10 yrs: 36	Hospital: 45
			M: 10	>10 yrs: 27	Non-hospital: 18
11. Greece	58	4.8	F: 50	<10 yrs: 41	Hospital: 52
			M: 8	>10 yrs: 17	Non-hospital: 6
12. UK	53	4.4	F: 48	<10 yrs: 36	Hospital: 35
			M: 5	>10 yrs: 17	Non-hospital: 18
13. Turkey	52	4.3	F: 49	< 10 yrs: 40	Hospital: 50
			M: 3	>10 yrs: 12	Non-hospital: 2
14. Philippines	49	4.0	F: 32	<10 yrs: 41	Hospital: 33
			M: 17	>10 yrs: 8	Non-hospital: 16
15. Italy	48	3.9	F: 36	<10 yrs:14	Hospital: 23
			M: 12	>10 yrs: 34	Non-hospital: 25
16. South Africa[†]	48	3.9	F: 40	<10 yrs: 25	Hospital: 15
			M: 7	>10 yrs: 22	Non-hospital: 33
17. USA	40	3.3	F: 32	<10 yrs: 22	Hospital: 29
			M: 8	>10 yrs: 18	Non-hospital: 11
Total	1217	100.0	F: 1016	<10 yrs: 720	Hospital: 776
			M: 198	>10 yrs: 496	Non-hospital: 441
			Other: 2		

[†]Missing one value for gender and years of experience.

The entire analysis was supported by *NVivo12* software. One researcher analysed, coded and went through several rounds of searching, reviewing and defining the themes. The themes were discussed, reviewed and finalized with other members of the research team.

Rigour and Trustworthiness

Methodological rigour was ensured by involving additional five members of the research team in coding some of the raw data from a few countries, and comparing the emerging categories and themes. Any coding discrepancies were

discussed and resolved with the principal investigator during regular weekly team meetings. In addition, a coding manual was produced providing a detailed audit trail of the process.

Results

Three main themes were revealed and labelled as (a) manager-related, (b) system-related and (c) staff-related obstacles to compassion (Figure 1). Figures 2, 3 and 4 contain bar charts, each representing data for each of the sub-themes identified. Each bar represents the percentage of text coded for that theme for each country.

Theme 1: Manager-related obstacles to compassion

Sub-theme 1.1: Managers' personal characteristics and experiences
This sub-theme covers obstacles to compassion which can be attributed to the managers' feelings, beliefs, knowledge, skills

and personalities. Participants from all countries, with the exception of those from Turkish-speaking Cyprus (TC), found that aspects pertaining either to the character or the life experiences of the manager could have an enormous impact on their capacity to be compassionate (Figure 2a). Participants from South Africa suggested negative personality traits in terms of arrogance, self-centredness and selfishness, rudeness and lack of leadership skills. 'Oppressive leadership style', 'lack of cooperation', 'autocratic leader' and 'non-consultative [leader]' are some descriptives used by them. One participant referred to the manager's experience of conflicts in the workplace:

> Usually the background of the manager, it could be their history with other managers, or they have grudges that is making them not compassionate to their staff (South Africa – ZA)

Other participants pointed to the insecurities that managers may have, such as:

Figure 1 Synthesis of results.
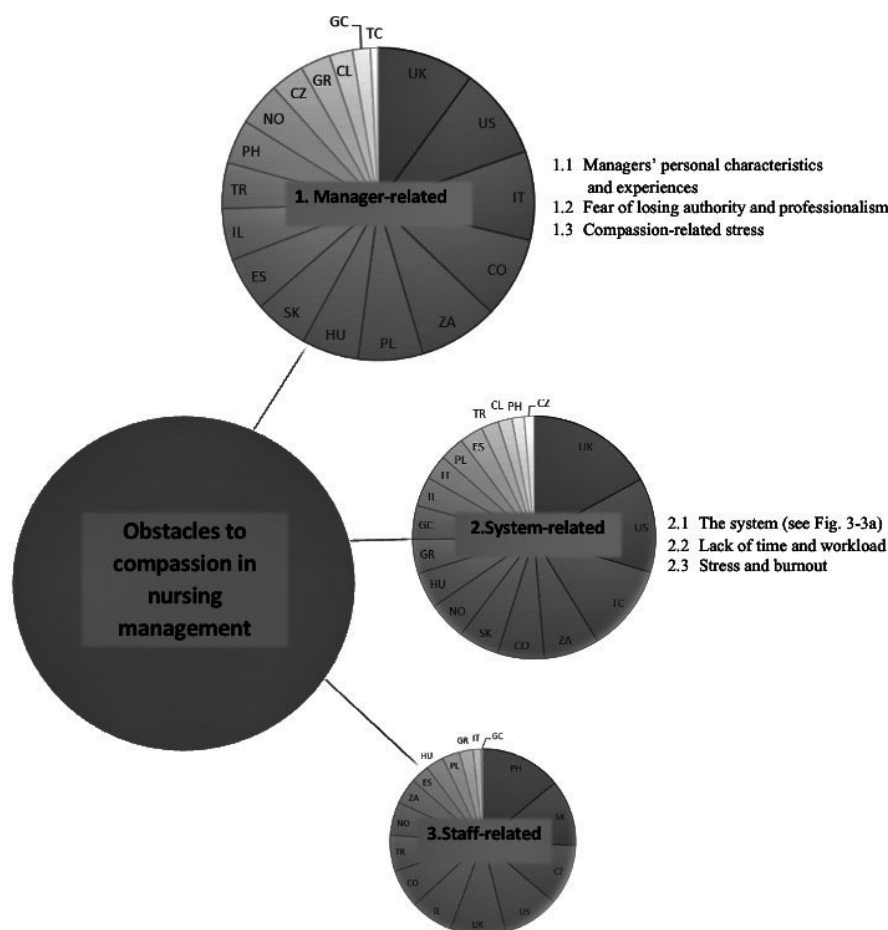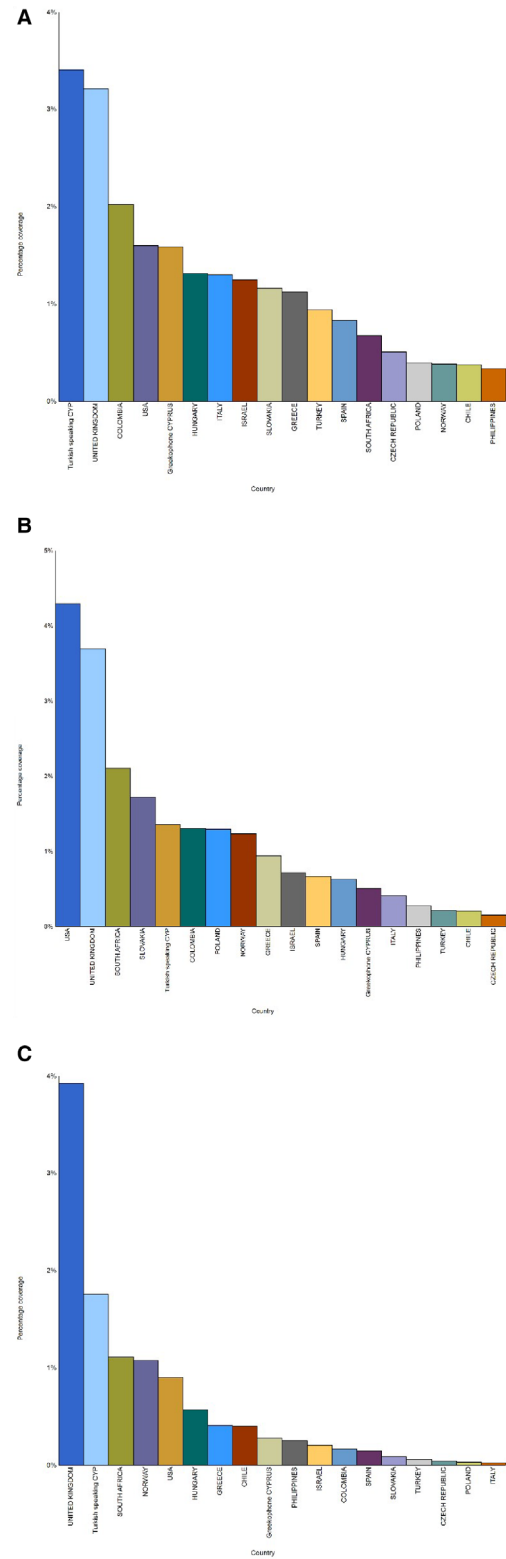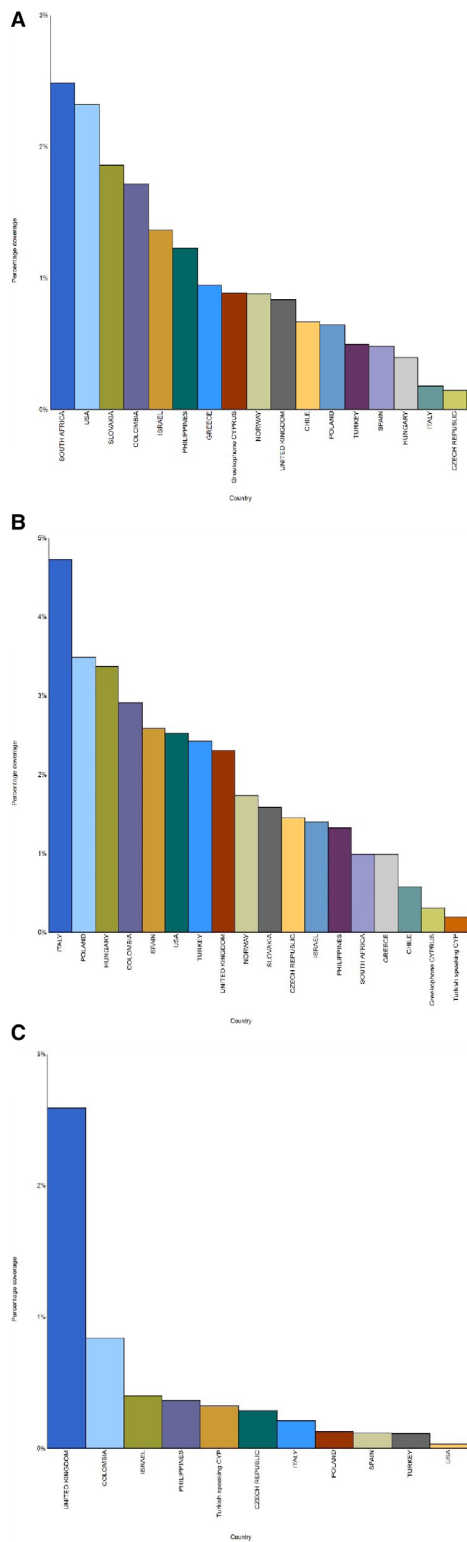
Figure 2 (a). Manager-related obstacles. (b) Fear of losing authority and professionalism. (c) Compassion-related stress. [Colour figure can be viewed at wileyonlinelibrary.com]

Figure 3 (a) The system (system's rigidity, lack of training, issues with senior management). (b) Lack of time and workload. (c) Stress and burnout. [Colour figure can be viewed at wileyonlinelibrary.com]

Percentage coverage

Country
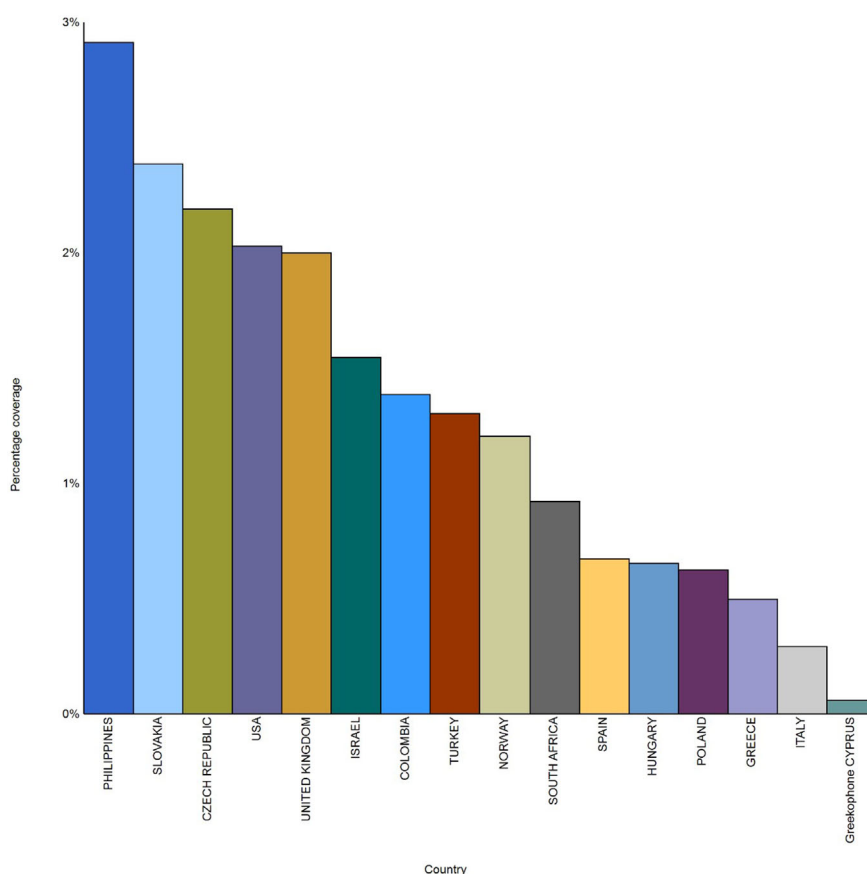
Figure 4 Staff-related obstacles. [Colour figure can be viewed at wileyonlinelibrary.com]

A manager who lacks confidence because, either of [lack of appropriate] qualifications or other personal attributes (ZA)

[The manager] adopts an autocratic leadership style due to her feelings of inferiority (ZA)

In contrast, participants from Slovakia stated that the chief barriers to compassion were the managers' attitudes, such as 'feeling superior' (Slovakia – SK). Other negative characteristics were given:

Envy, intoxication by power, wealth, focus on particular members of the team only (SK)

Distrust, breach of trust, wrong person at the position of a manager, feeling of power, snobbism, unfamiliarity with the situation of the others (SK)

Participants from the United States expressed their concerns in relation to managers' personalities and experiences. One participant declared:

Taking things personally, like employees' complaints or morale. Lack of emotional intelligence or experience as a manager (US)

Participants from the Greek-speaking Cyprus (GC) associated the obstacles with the gender of the manager by stating, 'Character, usually women when they become managers' (GC).

Sub-theme 1.2: Fear of losing authority and professionalism

All participating countries identified the fear that, by having a compassionate approach, managers would lose their authority and professionalism. Especially participants from Italy and Poland felt that they would run the risk of 'being seen as weak' (Italy – IT) or 'lowering their authority' (Poland – PL) (Figure 2b). Other examples include:

Fear of looking weak, fear of becoming too familiar with the staff (IT)

Fear of being identified as a person lacking firmness, personality, authoritativeness (IT)

Fear of losing control of the staff (PL)

You cannot show compassion because they will jump on your head (PL)

Others clearly expressed fears in relation to losing the 'right distance':

Fear of excessive entanglement in private matters, difficulties in separating private and professional life (PL)

Too short distance with the employees, blurring boundaries between supervisor-subordinate (PL)

The fear/risk of not keeping the right distance, of losing objectivity in the evaluation (IT)

The fear of losing authority by giving compassion appears to drive some managers towards emphasising rules, tasks and results, and an attention to avoid favouritism by adopting an 'everyone must be treated the same' approach. Italian participants, followed by those from Hungary, United States, Spain and Colombia, stressed these obstacles to compassion. However, the emphasis on rules and tasks may not always be the result of fear of losing authority, but a perception of priorities. A participant from the United States stated:

Too many distractions or tasks makes relationship building not a priority, staff come to be viewed as workers and not as team members (US)

In Hungary, a focus on rules was not necessarily seen as a problem hindering compassion, rather as the right conduct in nursing management, as one participant implied when stating that it was more important to: 'work efficiently with task-specific assignments' (HU). Other Hungarian (HU) participants declared:

I am observing and enforcing the bonds of the law (HU)

[It is important to] work efficiently with individual skills to meet your requirements (HU)

Participants also linked the loss of authority and professionalism to notions of pity and religion. Pity was linked to sadness, as well as commiseration and indulgence, particularly by participants from predominantly Christian catholic countries. For example, a participant from Spain (ES) defined compassion as '*helping someone motivated by pity and sadness*'. Participants expressed the view that being motivated by sadness and pity may influence the objectivity of managers, which in turn may lead to loss of control and professionalism. This conception was echoed by others, who affirmed that:

For me compassion is letting yourself be carried away by the sadness you feel for other people's problems (ES)

Participants from Colombia (CO) also linked compassion to pity and to a negative emotional spectrum considered inappropriate for working relationships. One participant wrote:

I consider that being compassionate is to feel sorry or pity for a person, something which I do not share, because this underestimate or undervalues a person (CO)

Italian and Polish participants stated:

Compassion is PIETAS [piety], a manager must not be compassionate, but empathetic in order to analyse and understand the different points of view (IT)

A manager consider their staff as a group to work with and grow together, not as someone to be pitied (IT)

Compassion is weakness (PL)

At work, we have to be professionals. You should leave your feelings, grievances and sorrows away from the ward, it does not help in caring for a sick person who has much bigger problems than we do (PL)

The idea of losing control of staff through compassion-giving is also present among the Turkish (TR) participants:

Defending the necessity to have the control, fear of failing to manage [...], fear of failing to work professionally [...] (TR)

We had been managed by managers who were far from compassionate for years. I am still angry with some of my managers from the past. Indeed, I used to believe that they must have had no family, kids or patients. You will be appreciated as long as you are strict (TR)

Sub-theme 1.3: Compassion-related stress

Compassion is seen as demanding and, as a result, a cause of increased stress. Participants from the United Kingdom (UK) expressed this issue more than all the other eleven countries where this component was found (Figure 2c). Often, this was articulated along the lines that managers feel unsupported, and therefore can experience 'compassion fatigue'.

It can be hard to be continually compassionate without receiving support (UK)

Too many demands on time, too many staff to manage. Under stress from own work pressures and experiencing compassion fatigue (UK)

The stress-inducing demands for a manager were articulated as personal investment, hostile workplaces, lack of time, and working with peers and superiors who were unpleasant. For example,

The work environment of health is painful and hostile... (CO)

The work we do is very demanding in terms of personal involvement (CO)

My fear is coping with my emotional difficulties and those of others, and lack of time for "self-care" (Israel – IL)

Emotional and intellectual burden, incessant role demands and demands from insensitive people with an unpleasant character and personality (IL)

Theme 2: System-related obstacles to compassion

Sub-theme 2.1: The system

Issues with senior management and lack of training are some of the system-related obstacles reported. Participants from TC, UK and CO opined (Figure 3a):

Compassion should be taught in our schools because very few healthcare professionals are able to give it to their staff members (TC)

I think we need to be given training in how to be more compassionate (TC)

I feel I am a very good trained nurse, but have had no formal training as a manager, and some of the team members' characters are complex and require expert handling (UK)

Not having training processes in personnel management (CO)

Others referred to rigid and archaic administrative structures and rules:

At a managerial position being compassionate is important, but the government is making us work under conditions that make nearly impossible to give compassion (TC)

A system that does not give the autonomy to managers to create a working environment where compassion is encouraged and practised. Many times, the system that exists in public hospitals creates difficulties for the staff (e.g. not flexible working hours, or work in the department of preference) (GC)

The characteristics of a system, which leads us to quantify everything and to focus more on the 'provision of a service', ignoring the individual characteristics and hidden burdens of each person (CO)

Good management is empathic, work friendly, forward-looking, inspirational and exemplary, it can plan because it is on firm feet, but nowadays it cannot be said in Hungarian healthcare system (HU)

Sub-theme 2.2: Lack of time and workload

With respect to workload (Figure 3b), participants across countries provided an array of short examples: 'being busy', 'being overworked', 'inability to meet all demands, operational and staff', 'too much on their plate', to more elaborate, such as:

At times, there can be a conflict of interest as you want to offer compassion, but on the other hand the organisation puts deadlines and pressure on that, meaning you may not be as considerate as you want to be, as deadlines have to be achieved so that the service can be provided (UK)

... not all managers are up to the job and have been promoted above their ability and skills...[they] are threatened and out of their depth, and are rarely compassionate as they are too busy surviving (UK)

Participants from Greece (GR) offered insightful statements in relation to harsh working conditions and heavy workload, due to lack of personnel which hampers the establishment of good communication with staff. For example,

Heavy workload makes communication between head nurse and the rest of the staff impossible most of the time (GR)

Burden of work and the lack of personnel in hospitals (GR)

The under-staffing that forces us to have employees with 30 years of service in night shifts, which is unacceptable (GR)

Lack of time and excessive workload were not, or rarely, reported by participants from the Philippines (PH), Czech Republic (CZ), Chile (CL) and GC (Figure 3c).

Sub-theme 2.3: Stress and burnout

Stress and burnout obstructed compassion, particularly in the UK and TC (Figure 3d). A manager confessed:

Unfortunately, if it were not for my family, I would not be able to hold this position. We are taught everything except how to care for each other and it is draining sometimes (TC)

South Africa, Norway (NO), United States, Hungary, Greece and Chile reported that stress and burnout were barriers to compassion (Figure 3c). These quotes encapsulate the stress that managers experience and the perceived competing demands:

If you are on sick leave it is expected that you go to work to do something. When you are partially on sick leave, it is expected that you go to work every day but do less, it is hopeless for a manager. No, now I have conducted so many conversations, now I have to rest. That is not good (NO)

In the morning I always try to establish a dialogue [with my staff]; however, there are times that the pressure to perform tasks becomes more pressing than listening to people, so I am always alert and wonder whether I'm truly listening (CL)

Theme 3: Staff-related obstacles to compassion

Managers from 16 countries expressed concerns regarding how compassion was received by their staff. Linked to the component of fear of losing authority and professionalism

discussed above, this third theme covers the perceived risk that staff may misuse or abuse the compassion that they receive (Figure 4). Concerns emerged also in relation to 'bad' employees. The Philippines is the country where this problem was mostly felt. A number of participants expressed concerns similar to the following:

> When the manager feels that subordinates abused his/her kindness and their respect for his/her position …when subordinates forget the professional boundary the manager sets (PH)

> When staff become abusive with your kindness and given considerations (PH)

> Manager who feels and has proofs that he or she is being abused should stop showing compassion (PH)

In two Central-Eastern European countries (Slovakia and Czech Republic), this issue appeared strong too (Figure 4):

> Compassion is important, but one should not push it because some people make ill use of it (SK)

> They can misuse compassion. According to some, such compassionate managers are not able to lead (SK)

> There may be misuse of tender-heartedness (SK)

Several managers from the Czech Republic showed similar concerns:

> It is impossible to be compassionate always. It happens that, subsequently, misuse will occur (CZ)

> I understand that a worker has a seriously ill partner or child and he/she selflessly takes care of them. Of course, he/she must not misuse this situation at the expense of his/her duties (CZ)

Expressions such as 'hostile behaviour of subordinate workers', 'bad work, lying', 'abuse of his/her willingness and goodness', 'hate from staff, aggression' – all coming from Czech participants – indicate the existence of, or the potential that, staff–manager relationships are not rooted in respect and compassion.

Discussion

This international study explores opinions and perceptions of nursing and midwifery managers from 17 countries regarding the obstacles to their compassion-giving. The article provides evidence on the shortcomings of healthcare structures, which impact on compassionate management. Three main themes were identified across countries, with some obstacles being more prominent in some countries than in others. Emerging from the evidence were the broader concepts of power and human rights, both of which appeared to influence managers' leadership styles. Our findings resonate with recent evidence (Coffey et al. 2019) and describe organizational challenges and failures resulting from the need of more resources and

training, and, in some cases, the need of support for the promotion of compassionate work cultures (Bridges et al. 2017; MacArthur et al. 2016). The findings also indicate that the organizational values, as well as the cultural values of the leaders, impact on their perceptions and ability with regard to providing compassion to their staff and their peers.

Compassion has been shown to be fundamentally linked to physical, social and cultural milieu (Roze des Ordons et al. 2019; Singleton & Mee 2017). It has been established that organizational and socio-cultural values and norms greatly influence leadership styles (Chhokar et al. 2007; House et al. 2004). Our data have revealed that a key obstacle to giving compassion lies with how managers use their power in order to enact their role, based on their personal characteristics, experience and leadership style. To understand the reasons for the obstacles to compassion-giving by managers in healthcare settings, and envision ways to address it, it is useful to consider the sociocultural configurations of each country and their organizational cultures. For example, according to House et al. (2004), the two culture clusters of Central-Eastern Europe and Sub-Saharan Africa – to which Slovakia and South Africa, respectively, belong – are culturally similar, and both scoring high in power distance and assertiveness. In relation to leadership, both clusters value high performance and decisiveness. This could potentially provide an explanation about the fact that, in our study, both Slovakia and South Africa scored high in relation to negative managers' attitudes.

Cultural, and particularly religious, values appear to explain another finding: the fear that, by having a compassionate approach, managers will be perceived as weak, and would lose their authority and professionalism. Italy, Poland, Spain, and Colombia are countries with predominant Christian Catholic values, which influence the cultural values at personal and societal levels (Tavanti 2012). In these countries, compassion was conceived in terms of pity, associated to an emotional weakness that can lead to loss of power, impartiality, fairness, distance and control. Fear of being compassionate has been found to be positively associated with an antisocial leadership style, which is characterized by aggressiveness, lack of remorse and insensitivity (Basran et al. 2019). It is important to note that, if such fears are not acknowledged or addressed, they can hinder the efforts to promote compassionate leadership.

Staff-related obstacles to managers giving compassion have highlighted the existence of team relationships that are not fully grounded in mutual trust and respect. Participants from the Philippines reported that staff misuse or abuse their managers' compassion. A study conducted in another Southern Asian country, Malaysia, found that cultural beliefs have a great impact on the establishment of a positive relationship

between leaders and their staff (Jogulu & Ferkins 2012). Even though collectivism is associated with compassionate leadership, a toxic version of in-group collectivism exists – the so-called 'padrino system' – whereby people are appointed and promoted because of family relations or friendship. The scarce meritocracy and the higher favouritism inject toxicity in the workplace at the detriment of trust and ethics, thereby providing a strong link to potentially disregard human rights. This cultural trait supports our findings regarding the relevance of culture in determining workplace relationships and organizational values (Tsai 2011).

The UK and United States scored among the top countries in relation to both manager- and system-related obstacles (Figure 1). Considering that both countries report high healthcare expenditures (World Bank 2016), it is interesting that system-related obstacles to compassion are so prominent. This result in the UK is also consistent with the recent evaluations of the policy on compassionate care which was launched in 2012. It was found that many nurses felt that the policy and implementation initiatives failed to address adequately the many organizational barriers that they face every day in their workplace, such as staff shortages (O'Driscoll et al. 2018). In the United States, a predominantly individualistic country with a focus on productivity and fear of litigation, our evidence suggests that managers–staff relationships are characterized by distrusts and self-protection, especially in the case of inexperienced mangers. In the UK and Norway, acknowledged to be individualistic countries, the expression of self-protection was in terms of stress and compassion fatigue (Figure 2c). Participants from collectivist countries, such as Chile, Turkey and the Philippines, generally expressed less concern regarding system-related obstacles to compassion. Since in collectivist countries the working environment is characterized by close and supportive relationships, even beyond the working hours, this appears to compensate for system-related deficiencies.

Study limitations
Online questionnaires allow the collection of a large amount of data in a relatively short period of time. However, a few limits can be highlighted: first, the inability to know the actual number of people the survey reached and therefore calculate response rate; second, the different sample sizes for each country; and third, the relative limitation of the data collection tool with only a few open-ended questions. It is recognized that conducting semi-structured interviews would have provided additional information on the topic, for example.

Conclusion
Obstacles to compassion are attributed to manager-, system- and staff- related factors that vary across countries. An understanding of the variations across countries and cultures of what impedes compassion to flourish in health care is important, and the use of a model of culturally competent and compassionate leadership in health care is called for. Ultimately, compassionate working environments will nourish both managers and front-line staff, as well as patients and their families.

Implications for nursing practice
To our knowledge, this is the only study that explores obstacles to compassion among nursing managers at an international level and that also attempts to delineate their cultural aspects. Our findings suggest that in order to limit the obstacles to compassion-giving, managers should wisely use the power they possess by adopting leadership styles that promote culturally competent and compassionate workplaces. Understanding the interplay of culture, compassion and leadership in the delivery of compassionate care is critical, with more reports from different countries highlighting some aspects of this issue. For example, Iranian nurses reported that a major obstacle to compassion was the different sociocultural challenges that they faced in their everyday practice (e.g. caring for patients from other countries who spoke a different language) (Babaei & Taleghani 2019), whereas nurses in Malawi reported that unsupportive leadership inhibited the provision of compassionate care to their patients (Msiska et al. 2018).

Papadopoulos (2018) recommends that leaders need to develop the following key elements: 'deep self-awareness; proper self-love; genuine interest for our fellow humans; compassion for self and others; measured courage; non-exploitative relationship; and professional competence' (Papadopoulos 2018, p. 84). The evidence regarding the positive association between the value of cultural competence and the altruism of compassion in leadership is steadily growing. This aligns with the Global Nursing Leadership Program of the International Nursing Council that recognizes the importance of nursing leaders to be guided by a strong moral compass and altruistic values (Salvage & White 2019).

Implications for nursing policy and education
Policymakers and nursing education authorities should identify training and mentoring strategies to enable the development of managers' practical wisdom, which is at the heart of culturally competent and compassionate leadership. National and transnational policies should also introduce guidelines and support mechanisms to enable shared definitions and

practices around compassion-giving at all levels of the healthcare systems. Such guidelines should stem from a balance between positive emic conceptions and transcultural human rights frameworks. They should also aim at influencing organizational culture and values in way that compassion-giving is seen as helpful to staff, the organization as a whole, the patients and the managers themselves.

The study suggests the need for clear institutional policies related to addressing the shortcomings of healthcare systems which impact on compassionate management. It is important to note that as nurses from different countries consistently report organizational and structural barriers to compassion (Ledoux et al. 2018; Valizadeh et al. 2018), the same issue is highlighted by nursing managers in this study. Therefore, appropriate national and international policies should facilitate the establishment of standards for compassionate leadership in the face of organizational and system-related obstacles for compassion-giving, which are the product of lack of resources and training, and, in some cases, connected to the sociocultural configurations of each country and their organizational cultures. The development of guidelines should pivot around evidence-based knowledge, people skills, and a commitment to fairness and human rights.

Acknowledgements

Authorship contributions

Study design: IP
Data collection: All authors
Data analysis: IP, RL, CK
Study supervision: IP
Manuscript writing: IP, RL, CK
Critical revisions for important intellectual content: IP

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