Nurses' Experiences and Expectations for Compassionate Leadership and Compassion in the Working Community - A Qualitative Study

Mari Helena Salminen-Tuomaala (mari.salminen-tuomaala@seamk.fi)
Seinäjoki University of Applied Sciences

Satu Seppälä
Seinäjoki Central Hospital

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Abstract

Background

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

Methods

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

Results

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

Conclusions

Compassion can be regarded as social capital, essential for nurses' coping and wellbeing in clinical nursing characterized by constant changes and critical situations. Immediate supervisors have a crucial role in promoting a compassionate atmosphere. They can express compassion by being physically present and by fostering an open dialogue in the working community.

Background

Today's working life appears to expect us to be effective and untiring, without paying very much heed to our other attributes as human beings. We are, however, shaped by our various emotions and experiences, not simply by the need to "perform" effectively. There seems to be an increasing call for compassion (1) and for creative, resource and potential-oriented thinking in the world of work, including the healthcare context (2).

An increasing body of literature on compassion and compassionate leadership seems to be emerging. Compassion is a core value in the Code of Ethics for Nurses of the International Council of Nurses (3). It has been defined as awareness of another person's suffering, feeling for it and motivation to act to share or alleviate the universal experience of suffering (4, 5). Compassionate leadership has been claimed to require emotional intelligence, including knowledge about emotions, ability to apply the knowledge in emotional situations and the tendency to use emotional skills (6). These skills call for both

cognitive and affective and cognitive empathy, that is, both conscious reading of other individuals' perspectives and appropriate emotional responses to their emotions (7).

The concept of compassion was analyzed by Taylor, Hodgson, Gee and Collins (8), who stated that compassion is a complex, subjectively displayed term, for which no one agreed definition exists. Based on the results of their analysis, the authors suggest five defining attributes for compassion in the healthcare setting: cognitive recognition of another individual's adversities; personal connection with the individual; altruistic desire to help; humanistic response or understanding; and action or responsive behavior (8). Although set in the nurse-patient context, the defining attributes might be relevant for compassion between leaders and employees, or among peers. Alternatively, compassion can be viewed as a process consisting of three main elements: becoming conscious of another person's situation; emotional connection; and action taken to alleviate suffering (9)

Attempts have been made in healthcare literature to differentiate between compassion, empathy and sympathy. Sinclair et al. (10), for example, state that sympathy has usually been defined as an emotional reaction of pity, particularly toward individuals perceived as suffering unfairly, whereas empathy has been used to refer to understanding, and accurately acknowledging and responding to another individual's feelings. In many definitions, compassion appears to differ from sympathy and empathy in its proactive approach and the more selfless role of the responder (10).

Compassionate leadership has commonalities with dialogic, transformative and what can be called "appreciative leadership". These approaches seem non-authoritarian, characterized by "genuine" encounters, reciprocity, appreciation of individuality, listening and dialogue (2, 11, 12). Based on positive psychology, they stress solutions instead of problems (13). In addition, a model called Compassion in the Workplace has been recently suggested as a tool that can be used by leaders to assess their compassion levels and to facilitate the development of a compassionate workplace (14). It should also be mentioned that besides such widely recognized attributes of a compassionate working community as empathy, open dialogue and active reciprocal listening, self-care interventions are also receiving attention as part of an ethical work environment. (15). Nurse leaders and their staff are well advised to practice self-care to strengthen their resilience despite scarce resources, especially when faced with exceptional circumstances like the Coronavirus 2019 (COVID-19) pandemic (15, 16).

Nurses working in intensive care or emergency departments are in the frontline and frequently under significant pressure. This study seeks to provide a trustworthy description of these nurses' experiences of compassionate leadership and compassion in the working community. The knowledge can be used to promote nurses' coping and wellbeing at work. More evidence of the meaning of compassionate approaches is needed; there is still a dearth of national and international policies to introduce and promote compassionate leadership in health care (17).

Methods

Aim, Setting and Design

The study aim was to provide a trustworthy description of nurses' experiences and expectations for compassionate leadership and compassion in their working community at a central hospital in Finland. The study purpose was to produce knowledge that can be used to promote nurses' coping and wellbeing and to develop compassion and compassionate leadership in hospitals and other healthcare organizations.

Participants

The participants were 50 nurses out of a target group of 192 in intensive care and emergency departments of a central hospital in Finland. The response rate was 26%. Most respondents (42) were women, and most had several years' work experience in nursing ; 27% had 11-20 years, 17% 3-5 years, 16 % 21-30 years and 14% over 30 years' work history in nursing. The remaining participants had either less than 2 years' work experience of nursing (12 %), or did not respond to the question (14%).

Data Collection

All nurses of intensive care and emergency departments in a central hospital were contacted via e-mail through the Hospital Press Officer. An online survey tool (Webropol) was used to collect data from voluntary participants. The respondents accessed the link through e-mail and they were able to respond anonymously. Besides three background questions on the participants' gender, hospital department and nursing experience, the questionnaire contained the following open questions:

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

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

Data Analysis

Inductive content analysis was used to analyze the 27 pages of transcribed data (Times New Roman, font 12). After reading through the data several times, the researcher picked out and stored in separate Word files original utterances (sentences, ideas) that represented an answer to the research questions. The utterances were reduced to core contents and the reduced utterances grouped into categories representing similar contents. These categories were finally combined into higher level categories.

Rigor

Study permission was obtained from the Administrative Nurse Leader of the Central Hospital. Participation was voluntary and the participants' anonymity was carefully protected. The general practice

in the Hospital District is to require formal ethics approval only for studies involving clients or patients, so no ethics approval was obtained. The entire research process was guided by recognized research ethical principles (18). The choice of topic was partly inspired by the nurses' increased need for compassion during the COVID -19.

Some observations can be made on this study from the perspectives of transferability, credibility and confirmability. Careful reporting of the context, data collection and analysis can be claimed to increase the transferability of the findings. Careful and transparent description of the analysis also enhances credibility (19), along with the presentation of nurses' personal experiences (20), exemplified by their original contributions (21). An attempt was made to increase the confirmability of the findings by reporting all stages of the research process as carefully as possible. In addition, the researcher repeatedly returned to the original set of data to ensure that the interpretation was supported by evidence (22).

Results

The categories that emerged from the analysis as a response to the research questions are presented under five headings below. They involve:

(1) Meaning of compassion experienced in the working community

(2) Compassion received from leaders

(3) Expectations for compassionate leadership and needs for support

(4) Factors maintaining compassion

(5) Stress as a challenge to the maintenance of compassion

In addition, each of the five categories includes two to four sub-categories, marked in italics. The results also contain original quotes from the participants, who have been classified into categories based on the number of years they have worked in nursing.

Compassion Experienced in the Working Community

In the nurses' essays, compassion emerged as a form of *social capital in the working community*. The art of compassionate listening and hearing was emphasized as the most important element in this context. Moreover, compassion was associated with a positive atmosphere and continuous discussion, encouragement and open problem management. It was considered to be a core element of nursing, which could increase the sense of community among the professionals at the workplace. Compassion was also seen as a seedbed for empathy, mutual appreciation and respect. Other elements associated with a compassionate workplace included multiprofessional teamwork, positive learning experiences and constructive feedback.

The respondents recounted several positive consequences of compassion in the working community. Help received and expressions of compassion from colleagues were found to reduce stress, enhance coping and wellbeing at work and increase the will to reciprocate the support. A compassionate atmosphere had made it easier to understand work-related stress. According to the participants, “genuine encounters” between colleagues and caring for each other had helped them cope with challenging situations. They felt that the presence of compassion had allowed them to express various emotions and, despite their incompleteness, to be accepted without “guilt-tripping”. Compassion had made it possible to understand and learn from mistakes, and to accept colleagues as they were. Last, according to the participants, compassion and social support had also increased safety in the working community. To quote some of the nurses on compassion: ” It’s important to understand others, compassion creates safety in the working community” (work history of 6-10 years); “ It’s understanding and supporting colleagues in various situations” (work history of 21-30 years; and “ workers appreciating their colleagues” (work history of 11-20). One of the nurses wrote, “ It supports decision-making in nursing. Compassion helps to cope with psychological stress. You have the courage to talk about problems/ambiguous issues (work history of 21-30 years).

Secondly, *compassion received from leaders* was expressed as the leaders’ (immediate supervisors’) physical presence at the workplace. The importance of their participation in the daily routines was one of the major findings in this study. The participants described a compassionate leader as one who was easy to approach, listened to the employees and provided constructive feedback. A compassionate leader, according to the participants, was “aware of what was going on at the workplace” and assumed responsibility for sharing and forwarding information. In addition, compassionate leadership involved expressing interest in employees’ competence and coping. A compassionate leader was aware of the strains and stresses of shift work. In the participants’ own words, ”Compassion from the working community and supervisor creates safety and carries you. You know that whatever comes, you will receive compassion in the working community” (work history of 0-2 years), and “…the immediate supervisor of the working community appreciates the employees’ opinions and acts on them” (work history of 11-20 years).

The third sub-category of experiences of compassion in the working community that emerged in this study was labeled as *individualized compassion in the working community.* In practice, individualized compassion meant equal and flexible allocation of work shifts and an understanding attitude towards employees’ limitations and work-life balance challenges. According to the participants, compassion in the working life could ideally mean individualized work-time models, according to the employee’s life situation. The participants wrote, for example, ”…that everybody is taken into consideration as an individual, with their competencies and limitations” (work history of > 30 years), and “ Compassionate understanding is the alpha and omega of this profession” (work history of 21-30 years).

Compassion in patient encounters was the last sub-category to emerge in this section. The participants indicated that compassion received from leaders and colleagues was reproduced in their patient contacts. There, compassion involved empathic and genuine encounters with patients and family

members. It meant understanding the patient and family perspective and putting oneself into the position of patients or family members. Compassion was also associated with patient safety and with working as a competent, trusted professional ”for the best of the patient”. As one of the nurses put it, ” I think compassion is an important part of nursing practice, I’m sure patients have confidence in the nurse and feel safer, when the patient is genuinely encountered” (work history of 3–5 years). However, the participants also pointed out that compassion could be stressful; excessive understanding could be very exhausting. To quote a participant, “Compassion is important, but it can also be exhausting, if you always fully identify with another person’s emotional state (work history of 3–5 years).

Compassion Received from Leaders

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

According to the participants, compassionate leaders were interested in supporting the coping of employees, for example by listening to their wishes and allocating shifts individually. Accommodating private needs in a flexible way, whenever possible, was considered an important quality in a leader. Compassionate leaders expressed empathy and offered support to employees facing various adversaries in their private lives.

The participants further described compassionate leaders as persons, who facilitated professional development. Such leaders were present, provided “occasional positive feedback”, but “did not demand too much”. They involved their employees in development efforts and were open to divergent views. To quote the participants, “The supervisor is interested in your work and coping, listens to you, supports you and asks, how they can help” (work history of > 30 years), and “ …comes to say hello to the employees in the morning” (work history of 21–30 years).

In contrast, the majority of the contributions in this study dealt with *negative experiences* and lacking or random acts of compassion from the leaders. One of the participants wrote, ”It is not expressed, I have a feeling that my supervisor doesn’t know much about my work …negative emotions are not allowed… (work history of 3-5 years).

These negative experiences involved the feeling of not being listened to and heard. In some of the contributions, leaders were described as distant and silent. The participants reported responsibilities being delegated or instructions being followed to the letter, which had led to “management by criticism”. Other experiences involved leaders’ impulsive and sometimes unexplained decision-making, and negative attitudes towards problems addressed by employees. According to some participants, the leaders did not understand their perspective and were unaware of the strains and stresses of their work. Many nurses seemed to feel they had been left to fend for themselves without a choice. In addition, the participants felt that their supervisors did not support or defend them.

To sum up, the participants' experiences varied a great deal, depending on the leader and the nurse. An experienced nurse wrote, " There are many supervisors in a big department. One makes nice small talk and that's enough, another takes care of practical issues, and still another does not even say hello or answer any acute questions" (work history of 21-30 years).

Expectations for Compassionate leadership and Needs for Support

The third category in the findings of this study contains the nurses' expectations for compassion and their needs for support from the supervisors. These needs and expectations were twofold: *psychosocial* and *psychophysical*.

The *psychosocial* expectations and needs communicated by the participants included the need to be given time, to be listened to and to be involved in open discussion on emotions and current situations at the workplace. The nurses wanted the leaders to express interest in them as persons. In addition, the participants wished for trust and co-operation between leaders and employees. Moreover, the nurses expressed the need to be equally appreciated, supported and encouraged.

According to the participants, it was also important for the leaders to provide personal feedback and encouragement in stressful situations. The nurses hoped for understanding and time to adjust to the constant changes. As one of the participants put it, "…to understand that it takes time to adjust to the changing working environment, you can't master everything at once" (working history of 3-5 years). In addition, the nurses expected their immediate supervisors to act as their advocates and to be genuinely concerned about their coping. In practice, this could mean more flexible and individualized shifts to accommodate for the nurses' different backgrounds and situations. The nurses also wished, for example, that during the Covid-19 pandemic, the working community had stopped to reflect on what had taken place, how well the staff had coped with the challenge, and what could still be developed. One of the participants wrote, " …that they would notice that we have once again managed a difficult time." (working history of 11-20 years). Some nurses also wished that in case of conflicts, more time was allocated for listening to all parties before any conclusions were reached. They pointed out that the rest of the working community should not be informed of "unfinished issues".

In short, the participants wished for the application of "positive psychology". They would appreciate a greater amount of positive and constructive feedback, mutual listening and genuine dialogue. The nurses wished that the leaders expressed an interest in their professional competencies and that their individual strengths were recognized and appreciated. They also expressed the wish to share the joy of succeeding in their tasks.

Secondly, the nurses brought up some *psychophysical* expectations and needs. They said that they would appreciate the physical presence and availability of their immediate supervisors. Large departments typically have several supervisors. The participants suggested that permanent supervisors would be better aware of the daily routines and situations in the working community and thus better

prepared to offer support. Face-to-face performance appraisals were considered as useful opportunities to express one's wishes and objectives for professional development.

Factors Maintaining Compassion

Three sets of factors were found to maintain compassion in the working community. In the analysis, they were labeled as *social skills, resilience skills* and *individual skills.*

Social skills here refers to pleasant and kind behavior in the daily working life, such as friendly greetings, smiling and listening to each other. Many participants indicated that they wanted to be seen and appreciated beyond their work roles. Positive small talk and discreet inquiries about personal life, whether from colleagues or leaders, could help maintain an open and safe atmosphere and nurture compassion in the working community. One of the nurses wrote, "easy to approach, smiling, greeting, questions like 'how are you doing' "(work history of 0-2 years).

The results further revealed the importance *resilience skills*. Being united by common goals and success in dealing with difficult situations with help of a positive attitude and mutual support had helped participants maintain compassion in the working community. Many nurses seemed to find their work meaningful and appreciated the possibility "to belong", to be part of a community. Personal experience of compassionate support when faced with adversities had increased their will to support their colleagues. To quote one of the participants, "Good humor and an atmosphere that fosters open discussion, they help you go a long way" (work history of 11-20 years).

Finally, the sub-category *individual skills* discovered in this study refers to a person's ethical values, character and other individual attributes, which can support the maintenance of compassion at the workplace. According to some participants, employees themselves are also responsible for their coping and work ability. Personal recovery methods, time spent with family and friends, and other ways of improving one's work-life balance can help maintain a compassionate attitude. One of the nurses commented on this as follows, "Attention given to wellbeing, when you can cope better, it's easier to give compassion and support to others" (work history of 3-5 years).

Stress as a Challenge to the Maintenance of Compassion

This last category includes four sets of stressful factors, which the participants found to hamper the maintenance of compassion in the working community. They involved physical, psychological and social factors, as well as factors related to competencies and responsibilities. The difference between psychological and social factors here is that in the first, the emphasis is on inner, individual experiences, whereas the latter focuses on interaction and communication.

First, a number of *physical factors* were mentioned. The size of the working community was a major stressful factor. The participants found it difficult to maintain compassion at a workplace with a great

number of employees. They also experienced pressure, worried about ”doing it right” and felt that they did not have adequate free-time to recover properly. Some nurses reported having undertaken duties that did not correspond to their professional qualifications. In addition, lack of instruments and equipment was mentioned. One participant described the situation as follows, ”Challenging work, where you must take correct action, there is no space for mistakes” (work history of 0-2 years).

Secondly, the participants listed a great number of *psychological factors* found to be obstacles to the maintenance of compassion at the workplace. Hurry and stress were commonly mentioned. According to many participants, the stress was a result of a ”bad working atmosphere”, characterized by discrimination, unfair treatment of employees, egoism, jealously and bitterness. Having to assume too much responsibility, being ”pressured” and receiving negative feedback were also mentioned in this context. Some nurses reported fear of their superiors’ stress reactions and many felt that they were not supported or appreciated by their colleagues, leaders or the organization. Some of them sought reasons for the lack of trust; high staff turnover, constant orientation of new staff, not knowing one’s colleagues in the large organization, and the feeling of being dispensable were suggested. One of the participants described temporary staff as follows, “…passers-by exhausting your compassion/empathy, although it’s really not their fault…” (work history of 21–30 years). On the other hand, some nurses saw “the constant complaining” and dissatisfaction, and the habit of “using hurry as an excuse” as a negative factor for the development of compassion.

Third, the participants described *factors related to competencies and responsibilities*, which negatively affected the maintenance of compassion in the working community. Some of the nurses seemed to suffer from insecurity due to insufficient competencies. For example, ”If there are many things at the same time that affect your work, like hurry, lack of resources – of workforce, instruments, equipment- and if you don’t have the knowhow needed for the job” (work experience of 3–5 years). Other nurses, in contrast, described the opposite situation; they felt the burden of having to support inexperienced or inept colleagues. They found that the high staff turnover and great number of substitutes had forced them to take on too much responsibility. One of them wrote, “…constantly having to deal with inexperienced staff” (work experience of 6-10 years). In addition, the participants mentioned duties that did not correspond to their professional qualifications, or their tasks being reduced to routines. Some of them felt that they ran the risk of becoming cynical and losing their motivation.

Last, some *social factors* were found to hamper the maintenance of compassion in the working community. Partly overlapping with the findings presented under psychological factors, the participants described a poor working atmosphere, negative attitudes and lack of empathy from colleagues or leaders, and “unresolved issues” at the workplace. The experience of being excluded as a new employee and even workplace bullying were indicated. Faultfinding and lack of appreciation between colleagues were also mentioned. To quote one of the nurses, ”Cliques, and excluding new workers …” (work experience of 0–2 years). Other problems described involved ”lack of manners” and difficulties in communication, especially lack of dialogue and listening.

Poor leadership was directly or indirectly indicated. Leaders were described as indifferent or ”underachieving” and criticized for not informing staff of upcoming changes and decisions. It was also suggested that organizational bureaucracy and hierarchies might produce various regulations, which increased the distance between leaders and front line workers.

Finally, it was suggested that doctors making their rounds were indifferent towards the patients, and their practices were “unclear”. In some cases, this had resulted in patient dissatisfaction and increased the need for support and compassion from leaders. According to one of the nurses, “ Negativity from both patients and workers…” (work history of 0-2 years).

Discussion

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

The nurses reported a pressing need for emotionally intelligent and compassionate nurse leadership, which in healthcare literature have been linked with empowerment processes and positive organizational outcomes (23, 24). As suggested in a large international survey, obstacles to compassionate leadership vary across countries. They may be related to the leaders’ personal characteristics and experiences, or they may be system or staff-related (17). Part of the nurses in this study seemed to think that compassionate leadership is something that can be learnt, whereas others appeared to consider it to be a trait. According to Ellis, for example (25), leadership knowledge and skills can be taught and learned. He demonstrated compassionate and transformational leadership as pertinent to nursing practice today, because they stress the development of people and the team, and require emotional intelligence. In addition, national and international standards and guidelines for compassionate leadership have been recently advocated (14).

In the nurses’ essays in this study, compassion was discussed from various perspectives, as expressed between colleagues, received from leaders or passed on to patients and family members. Self-care was discussed less. What was lacking, was reference to self-compassion. Both could be seen as a foundation for compassionate care, not as something narcissistic that fosters a culture of selfishness (26).

Another question might concern the differentiation between empathy, sympathy and compassion. Professional compassion “misunderstood”, combined with high expectations for nursing outcomes can easily lead to stress and exhaustion. Both nurses and leaders might benefit from reflection and

discussion on the differences between compassion, empathy and sympathy. All this is not to say that the lack of resources is not a genuine problem in many healthcare settings.

Conclusions

Compassion can be regarded as social capital, essential for nurses' coping and wellbeing in clinical nursing characterized by constant changes and critical situations. Immediate supervisors have a crucial role in promoting a compassionate atmosphere. They can express compassion by being physically present and by fostering an open dialogue in the working community. Investing on self-compassion and self-care are important for both nurse leaders and staff.

Abbreviations

COVID-19 Coronavirus 2019

Declarations

Ethics Approval and Consent to Participate

Study permission was obtained from the Administrative Nurse Leader of the Central Hospital. Ethics approval was not required. The need for consent is deemed unnecessary according to the Central Hospital regulations.

Consent for Publication

Not applicable

Availability of Data and Materials

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

Competing Interests

The authors declare that they have no competing interests.

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Authors' contributions

SS collected the data and MS-T and SS analyzed the data. MS-T wrote the manuscript in English. All authors have read and approved the manuscript and ensured that this the case.

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