

Compassionate Care Challenges and Barriers in Clinical Nurses: A Qualitative Study

Abstract

Background: Compassion is the heart of nursing care. Barriers to compassion in nursing may be influenced by the prevailing culture and religion of a society. Determining the barriers to providing compassion-based care would help nurses to plan better and more appropriate interventions. This study aimed to explore the challenges and barriers to compassionate care in nurses. **Materials and Methods:** This ethnographic study was performed in 2014–2016. The study participants consisted of 40 nurses, 16 patients, and 8 family members in medical and surgical wards. Data collection was performed through observations and interviews. Data analysis was performed based on Strauss and Corbin's constant comparative method. **Results:** Data analysis defined three themes as the challenges and barriers to compassionate care; challenges and barriers related to the contextual environment of hospitals, sociocultural challenges and barriers, and challenges; and barriers related to staff. **Conclusions:** This study described the challenges and barriers to compassionate care. Therefore, to eliminate these barriers and challenges, corrective action should be taken by managers. Attention to teaching the concept of compassion and patient-centered care and increasing the number of nurses and positive attitude toward the nursing profession in clinical environment can be effective in providing compassionate care.

Keywords: Challenges, compassion, ethnography, Iran, nursing

Introduction

Compassion is the basic characteristic in the quality of nursing care. It is considered as an essential principle of patient-centered care.^[1] The role of compassion-based care has become important between nurse and patient in recent decades. In literature, compassion is defined as mercy and sympathy along with action and caress.^[2] Furthermore, compassion is more than just the necessary care and includes empathy, respect, and recognition of personal characteristics.^[2] For nurses and caregiving organizations, this means to determine and respect patients' opinions, values, and beliefs. Despite all this, literature has discussed compassion as the lost art of nursing.^[3] According to the Agency of Healthcare Research and Quality, 10.8% of patients believed that healthcare providers do not listen to their words, do not clarify issues and procedures for them, and do not spend enough time with them.^[4]

Moreover, according to the report of the Care Quality Committee, 3% of patients

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believed that nurses treat them without respect.^[5] In fact, patients' perception of care is associated with a lack of respect and dignity by nurses.^[5] According to Proctor (2008), in the National Health Services (NHS), nurses try to provide high-quality compassion-based care. However, in accordance with professional standards, compassionate care was less evident in clinical situations.^[6] Even in a large and complicated organization, such as healthcare services, the patient's complete satisfaction remains a dream.^[7] Despite the importance of compassion-based care in increasing patient satisfaction, facilitating the process of returning home, and reduce treatment costs,^[1] there are some barriers associated with the nurse-patient relationship.^[8] The nurse-patient communication could also be affected by the culture of the society. In Iranian societies, a nurse is mostly considered a healer and caregiver and nurses' supportive and professional roles are less recognized.^[9]

Esmaeili *et al.* showed that some factors such as lack of cooperation among the

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medical team, lack of motivation in nurses, lack of a holistic approach, and lack of support organizations could be barriers to holistic care.^[10] Moreover, the nature of compassion-based care could also be affected by organizational factors.^[5] Fakhr-Movahedi *et al.* showed that although nurses and patients try to form a patient-oriented relationship, some factors such as culture, requisitions, and heavy workload in practice could limit it to problem-centered communication.^[11] Kwak *et al.* believed that the barriers to high-quality care include shortage of nursing staff, lack of time for caring, lack of knowledge in nurses, and lack of equipment.^[12] Attention to nurses' needs and requests would lead to nurses' attention to all the needs of patients.^[13]

Manongi *et al.* revealed that agreements and disagreements between nurses and patients are associated with the barriers to nurse-patient communication.^[14] Patients mostly believe that language, age, and sex differences; heavy workload; and bad temper of nurses are the barriers. Nurses believe that heavy workload and hardness of work, lack of amenities, physical and mental fatigue, and lack of an appreciative system are the barriers to patient-nurse communication.^[14] These barriers may be influenced by the culture and religion of a society. In Islamic societies such as Middle Eastern countries, religion plays an important role in nursing care quality.^[9] Determination of the barriers to compassion-based care can help the provision of more effective interventions. This study aimed to explore the contextual challenges and barriers of nurses in compassionate cares.

Materials and Methods

This was an ethnographic, multimethod study and considers the contexts.^[15] Nurses and midwives obtain cultural sensitivity through ethnography and can determine cultural impacts on individuals and groups.^[16] The adaptive nature of ethnography caused flexibility in data collection during the study.^[17] This research was performed in 10 medical and surgical wards of two teaching hospitals (Shahid Chamran and Alzahra) in Isfahan, Iran. The participants consisted of 40 nurses (32 women and 8 men) of different ranks, 16 patients, and 8 family members. The subjects were selected through purposive sampling. The first author of the study was invited to the wards to meet with the head nurses who introduced many of the staff.

Meetings were held with the nursing staff of each ward to introduce the study and to invite nurses to participate; consent forms were distributed at the end of each session. After obtaining consent forms from nurses, the first author made bedside visits to patients allocated to the nurse under observation and informed them about the study. Written consent was obtained from 40 nurses, 16 patients, and 8 family members. Verbal consent was obtained from nurses who interacted with the researcher and patients who were observed. Data collection was conducted

through observations and in-depth semistructured interviews from June 2014 to April 2016. The first author (interviewer or observer) was a nurse, but not one of the personnel of the selected wards; therefore, she was an outsider to the study environment.

During the first 20 days of the observations, the researcher was a complete observer and did not interact with the participants during the observations. However, she was an observing participant in subsequent observations, and she contributed to some nursing care activities. She also observed the behavior of nurses in caring situations such as tone, look, communication skills, touching the patient, standing beside the bed, listening to and empathy with the patient, and trying to relieve patient's pain. To avoid bias, the researchers observed only friendly and professional interaction with the participants during their observations.^[17]

Immediately after the observations, field notes were recorded. Each observation lasted 6–45 min. Participant observation was performed during a period of 20 months and for a total of 283 h. To complete the data collection, 40 nurses, 16 patients, and 8 family members from medical and surgical wards were interviewed. Moreover, the head nurses of wards were interviewed as key informants. Interviews were semistructured and lasted 25–70 min. The aim of the interviews was to determine the characteristics, challenges, and barriers of compassionate care nurses during daily care of patients. For example, interview questions included: When you want to show your compassion to your patients, how do you treat them? Do patients and their families speak with you about their problems, pains, and suffering? What factors affect compassionate care? What are the challenges and barriers for you to providing compassionate care?

Data collection was continued until the researchers were confident that no more new ideas, concepts, and categories could be extracted from the data and data saturation had occurred.^[18]

For data analysis, constant comparative method based on Corbin and Strauss's method was used. The use of the grounded theory in ethnographic studies focuses on the connection between events with constant comparison of data during data collection. The grounded theory raises the authenticity of an ethnographic research and compares and sorts the data.^[19] Data analysis began with verbatim transcription observations and recording of interviews by the first author. Then, the texts were read line by line. Furthermore, the observations and interviews were immediately written and codes were allocated to key terms and concepts. Labeling of codes was conducted using the words of participants and perceived concepts of the text.^[20] Similar codes were placed in one category and formed the categorization of codes. The categories with similar conceptual were located around a common and core axis. Then, categories with similar concepts and similar subjects were merged into axial.

To guarantee scientific rigor from criteria credibility, confirmability, dependability, and transferability were used.^[20] To ensure validity, time integration method was used. Thus, sampling was conducted three times at morning, noon, and night. Data credibility was ensured through member check. For this purpose, some parts of the interviews along with their extracted codes and groups were observed by the participants to evaluate data analysis and its accuracy. Additionally, data saturation was used to increase the reliability of the study. Audit trial and unbiased interviews, coding and categorization of data were used to evaluate the credibility of the study. To guarantee the confirmability of the study, the researcher recorded and reported the procedures of the study accurately, so it would be possible for others to follow-up on the study. Besides the main researcher, two other academic members also studied and confirmed the achieved results. Dependability was achieved through taking notes and reviewing all the data. Furthermore, transferability was achieved by interviewing different participants, presenting direct quotes and examples, and providing complete explanation of the data.

Ethical considerations

The researcher conducted the observations, recording, and interviewing with the consent of fieldwork participation and participants. Ethical considerations were recorded confidential.

Results

The age of the participants ranged from 21 to 78 years. Participants consisted of 40 nurses (32 women and 8 men), 16 patient, and 8 family members. The demographic data of the participants are shown in Tables 1 and 2. The main findings of this study had three themes; challenges and barriers related to organization and management, socio-cultural challenges and barriers, and challenges and barriers related to staff. The themes of this study are shown in Table 3. In the following sections, each theme and subtheme are explained with direct quotations from the participants.

Challenges and barriers related to the contextual environment of hospitals

At the organizational level and in the context of care, these factors lead to reduction in the quality and quantity of compassionate-based care and include the four subcategories of inconsistency between workload and its allocated time, the organization's inattention to the needs of the nurse, lack of a role model for compassionate behavior, and focus on routines instead of patients.

Large number of patients, presence of patients' families in wards, unstable condition of wards, along with insufficient nursing staff will lead to imbalance between the work time and workload of nurses. These factors reduce the chances of compassionate care. *"The workload is too heavy and the*

Table 1: Demographic data of the participants (nurses)

Variables	n (%)
Gender	
Male	8 (20)
Female	32 (80)
Age (year)	
<30	2 (5)
30-35	4 (10)
36-41	14 (35)
42-47	10 (25)
>48	10 (25)
Work experience (year)	
<5	2 (5)
6-10	6 (15)
11-15	8 (20)
16-20	12 (30)
>20	12 (30)
Education level	
Postgraduate	8 (20)
Graduate	36 (80)
Shift-work type	
Morning	16 (40)
Fixed evening	8 (20)
Fixed night	8 (20)
Internal rotation	8 (20)

Table 2: Demographic data of the participants

Variables	Patients, n (%)	Family members, n (%)
Gender		
Male	8 (50)	2 (25)
Female	8 (50)	6 (25)
Age (year)		
<30	0 (0)	2 (25)
31-50	6 (40)	6 (75)
>51	10 (60)	0 (0)
Education level		
Pre-diploma	8 (50)	0 (0)
Diploma	4 (25)	2 (25)
Graduate	4 (25)	6 (75)

staff is worn out, the number of personnel is not enough for the number of patients and it is not standard, and the patients are in really bad conditions..." (N5).

Nurses of medical and surgical wards had to put up with conditions caused by organizational culture and lack of human resources. They had to ignore their personal and professional needs.

Nurses believed that administrators' ignorance at the work place and lack of encouragement decrease nurses' motivation for achieving compassionate care.

Table 3: Themes and subthemes of barriers to compassionate care

Themes	Subthemes
Challenges and barriers related to the contextual environment of hospital	Inconsistency between the workload and its allocated time Inattention to the needs of the nurse by the organization Lack of a role model for compassionate behavior Focus on routines instead of patients
Sociocultural challenges and barriers	Gender as the determining factor of compassionate behavior Lack of a mutual language between the nurse and the patient Implausibility of friendly behavior in medical relations
Challenges and barriers related to staff	Personal and professional attitude of nurses Lack of a holistic approach to providing care

Nurses believed that such trainings do not prepare them for compassionate care. *“The concept of compassion has never been taught to us, not in university and not in the faculty. I might be intrinsically kind, but, since it is not my duty to be kind, I do not pay much attention to it...”* (N12).

Lack of a role model for nurses had an important role in the lack of kindness and compassion in nursing care. Participants stated that unsuccessful presence and passionless behavior of colleagues at the workplace could be an important barrier to compassion-based care. *“We had some experienced nurses who were like this all the time and always answered the patients indifferently and lethargically; it feels like I have been infected with indifference too...”* (N4).

The prevailing culture among nurses focuses on routines, which dictate predetermined duties instead of a unique and compassionate care. Nurses, due to their heavy workload, limited time, and incomplete understanding of their professional roles, provided care based on physicians’ prescriptions instead of providing holistic care. *“We only have enough time to take the vital signs and give patients’ drugs in one shift..., and managers do not expect anything else from use...”* (N8).

However, managers have an essential role in achieving compassion-based care for patients and it is necessary to pay attention to providing appropriate workplace, nursing personnel, and defined principles of compassion-based care.

Sociocultural challenges and barriers

The sociocultural barriers category indicates barriers that reduce the rate of compassion-based care. This category includes the three subcategories of gender of nurse, lack of a mutual language between the nurse and

the patient, and implausibility of friendly approaches in medical relations. Participants believed that gender was a determinant in performing compassionate behaviors and an important barrier to compassionate care. The study showed that young female nurses have problems in providing compassion-based care to male patients and they limit their communications with them in routine duties. A young female nurse stated: *“Sometimes, when you treat a male patient kindly or support them... it becomes problematic; I prefer to care for female patients and show them my care and compassion...”* (N10).

Some of the participants believed that the gender of the nurse was a cultural barrier to compassionate care for patients. *“I think that women are more compassionate than men and have a sense of femininity that men do not. I believe that men cannot get close to patients like women can; women have more delicate feelings.”* (P15). Lack of a mutual language between the nurse and the patient had a deterrent role in showing compassion. Some of the participants believed that lack of a mutual language was a barrier to providing compassionate care. *“Sometimes, the patient is an Afghan, Lur, or Turk, and we do not understand their language. I know that we should not discriminate between patients, but I feel these patients do not receive much kindness”* (N5).

In this study, most of the participants emphasized their therapeutic role without considering the mental and emotional contexts for the provided care. In the opinion of most participants, sharing feelings, intimate and friendly connection, physical closeness, touching, and eye contacts are not approved by the culture of our society, and a nurse is mostly considered a healer and caregiver and his/her supportive and professional roles are less known. *“This is not acceptable in our society. Once I had a patient who was an old man, I tried to support him emotionally, but he got the wrong idea and asked me to marry his son...”* (N10).

It is obvious that cultural and religious aspects play important roles in the expression of compassionate behaviors.

Challenges and barriers related to the staff

Individual barriers show obstacles that could decrease compassionate care at individual levels. This category includes the two subcategories of the personal and professional attitudes of nurses and lack of a holistic approach toward care.

In this study, individual attitudes of nurses in achieving compassionate care were important. In clinical care, it is necessary to engage both their mind and body in understanding compassionate care. In this study, most of the nurses believed that lack of interest and motivation, disbelief in compassionate care, and exhaustion were barriers to compassionate care. *“One of our problems at hospitals is that staff motivation is low, and this affects their work and decreases their kindness toward patients...”* (N6).

From nurses' point of view, external motivations such as income and salary affect compassionate care. "I spend a lot of time on my patient, and I provide every care that my patient needs, but my salary is not enough for all the work I do..." (N7).

Nurses mentioned that insufficient attention to holistic care could be one of the most important barriers to compassionate care. In the holistic approach, attention is paid to all the patients and their families. "When we care for a patient, we should not just focus on a specific problem., we should consider the patient's other needs and problems, and this would make patients satisfied..." (P13).

Moreover, nurses believed that routine work and insufficient clinical experiences were barriers to compassion-based care. "Nurses do not want to update their information. If they would think like this, they could not provide their patients with compassionate care" (F3).

According to nurses, having a holistic approach to care is necessary for providing compassionate care.

Discussion

This study was conducted to determine the barriers to compassionate care among clinical nurses. The results showed that compassionate care can be affected by many factors. These factors have also been discussed in previous studies. This study results showed the inconsistency between workload and its allocated time as one of the most effective factors in compassionateness. In fact, compassionate care will decrease with increasing work stress in nurses. Rassouli *et al.* argued that the large number of patients, presence of a companion with each patient in the ward, unstable condition of the ward, and lack of nursing staff lead to an imbalance between nurses' work and time. All of these generate stress in nurses, and consequently, reduce the chance of communication with patients.^[21]

This study demonstrated that authorities' ignorance of nurses' expectations is a preventive factor for presenting compassionate care. The results of the study by Babaei also revealed that workplace issues such as authorities' lack of attention to nurses' needs are inhibiting factors in the improvement of patient–nurse communication.^[13] Furthermore, the study by Kwak *et al.* revealed that organizational support increased the quality of care.^[12]

Esmaili *et al.* reported that organizational barriers to providing patient-based care were staff problems, problematic communication of nurse and physician, and insufficient support and encouragement for personnel.^[10]

Results of the this study showed that in-service trainings did not prepare nurses for compassionate care, and they preferred trainings that are more in accordance with the needs of compassionate clinical care. A systematic review revealed the significance of in-service training courses

in the improvement of skills and caring behaviors of nurses.^[22] West *et al.* reported that lack of nursing staff, time, insufficient access to equipment, and insufficient nursing knowledge are some of the barriers to offering high-quality care.^[23] In their study, nurses believed that the type and quality of in-service trainings were insufficient for improving their communicational skills and they required trainings that were matched with their communicational needs.^[23]

This study revealed that lack of a role model for compassionate behaviors at the workplace plays an important role in guiding nurses toward showing compassionate behaviors. In another study, lack of a positive organizational model for guiding beneficial care was a barrier to providing holistic care.^[9] In this study, imposition of caring duties on nurses in a task-oriented organizational climate decreased compassion toward patients. The organization's attention toward nurses' needs and requesting them to play their roles beyond routines and duties would cause nurses to pay attention to all the needs of their patients. Bolster and Manias stated that during nurse–patient interactions, while prescribing drugs, nurses were mostly focused on their task rather than caring for the patient.^[24] According to the study by Kourkouta and Papathanasiou, nurses' focus on their duties suggests that their duties are more important to them than the patients. Furthermore, patients believed that nurses have no authority and only follow the orders of other medical consultants.^[25]

The results of this study showed that gender was a determining factor and was considered as a cultural barrier to compassionate behavior by nurses. Traditionally, nursing care measures in Iran are based on Islamic standards and the governing policies of treatment and care.

Zaidi showed that when the nurse and patient have the same gender, the nurse is more motivated to talk about the patient's personal matters.^[26] In a study, gender difference between patients and nurses was considered an important cultural barrier to effective communication.^[27] Cultural and religious differences between Islamic and Western countries could explain these differences, because some compassionate behaviors such as touching the hands of the opposite sex are improper according to Islam, and to expand compassionate behaviors, Muslim nurses must work based on Islamic rules. In this study, the lack of a common language between nurse and patient played a deterrent role in compassionate care. Furthermore, in the study by Rassouli *et al.*, lack of a mutual language between patient and nurse was one of the inhibiting factors in the patient–nurse relation.^[21] The results of another study showed that nurses and patients who speak the same language communicate easier than nurses and patients with different languages.^[13]

The results of this study revealed nurses' emphasis on their therapeutic role without consideration of the mental

and emotional contexts for the provided care. Sharing the feelings, concerns, and worries of patients requires open, intimate, and friendly interactions, physical closeness, and touching, which in the opinion of most of the participants are not approved by the culture of our society. Nurses are responsible for starting and continuing a communication with patients and providing high-quality care. One of their professional duties is to create a friendly relationship with patients of any age and social class.^[28] A study also mentioned friendly relationship between nurses and patients as a cultural issue.^[23]

In this study, nurses believed that lack of interest and motivation and exhaustion are barriers to compassionate care. Esmaeili *et al.* showed that the lack of nursing staff, exhaustion, and lack of motivation were barriers to patient-based care.^[10] In a study, nurses' problems such as low salary, lack of personnel, and prolonged work led to nurses' weak approach toward their patients.^[29]

Lack of a holistic perspective and philosophy among nurses will direct them more toward physical care and performing physician's orders. Nurses' biomedical view in clinical situations was a barrier to emotional support and patient-centered communication in compassionate care. In another study, the barriers to a friendly relationship between patients and nurses were lack of adequate and comprehensive attention to communication between patients and nurses.^[30] In this study, nurses believed that personal efforts in using scientific methods was important for achieving a comprehensive caring approach. Fakhr-Movahedi *et al.* believed that one of the barriers to patient–nurse communication was insufficient information provided to the patient by the nurse and that nurses mostly do not have enough clinical information about the process of the treatment.^[11] The limitations of this study are related to the restrictions of the ethnographic and qualitative method of this research in that there is limited application for its findings.

Conclusion

Understanding the barriers and challenges of compassionate care can be the first step in solving nursing problems. Therefore, in order to improve compassionate care in nursing, steps should be taken to remove existing barriers and improve the facilities needed by the practitioners. Attention to human dimensions, holism in care, reducing nurses' care burden, and the emotional, physical, and mental needs of nurses is required. Observing the religious and cultural principles of society in the care of patients is also required. More attention to teaching the concept of compassion and patient-centered care in the clinical arena are among the most important issues to be addressed.

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Nothing to declare.

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