Research

The Importance of Being a Compassionate Leader: The Views of Nursing and Midwifery Managers From Around the World

Irena Papadopoulos, PhD, RM, RN, FHEA[1], Runa Lazzarino, PhD[1], Christina Koulouglioti, PhD, RN[1,2], Magdeline Aagard, EdD, RN[3], Özlem Akman, PhD, RN[4], Lise-Merete Alpers, PhD, RN[5], Paraskevi Apostolara, PhD, RN[6], Julieta Araneda-Bernal, MSc, RN[7], Sylvia Biglete-Pangilinan, PhD, RN[8], Orit Eldar-Regev, PhD, RN[9], Maria Teresa González-Gil, PhD, RN[10], Christiana Kouta, PhD, RN[11], Radka Krepinska, MSc, RN[12], Małgorzata Lesińska-Sawicka, PhD, MN, RM[13], Miroslava Liskova, PhD, RN[14], Alba Lucero Lopez-Diaz, PhD, RN[15], Maria Malliarou, PhD, RN[16], Ángel Martín-García, MSc, RN[17], Mara Muñoz-Solinas, MSc, RN[7], Małgorzata Nagórska, PhD, RM[18], Roinah Nkhensani Ngunyulu, PhD[19], Sara Nissim, PhD, RN[20], Line Nortvedt, PhD, RN[21], Ma. Florinda Oconer-Rubiano, MAN, RN[8], Cristina Oter-Quintana, MSc, RN[10], Candan Öztürk, PhD, RN[22], Katalin Papp, PhD, RN[23], Blanca Piratoba-Hernandez, PhD, RN[15], Elena Rousou, PhD, RN[11], Maria Ymelda Tolentino-Diaz, PhD, RN[24], Valerie Tothova, PhD, RN[25], and Akile Zorba, PhD[26]

Abstract

Introduction: Despite the importance of compassionate leadership in health care, many of the existing publications do not account for the effect of culture. The aim of this study is to explore the views of nursing and midwifery managers from different countries in relation to the definition, advantages, and importance of compassion. **Methodology:** A cross-sectional, descriptive, exploratory online survey was conducted across 17 countries, containing both closed and open-ended questions. Data from $N = 1,217$ respondents were analyzed using a directed hybrid approach focusing only on qualitative questions related to compassion-giving. **Results:** Four overarching themes capture the study's results: (1) definition of compassion, (2) advantages and importance of compassion for managers, (3) advantages and importance of compassion for staff and the workplace, and (4) culturally competent and compassionate leadership. **Discussion:** Innovative research agendas should pursue further local qualitative empirical research to inform models of culturally competent and compassionate leadership helping mangers navigate multiple pressures and be able to transculturally resonate with their staff and patients.

Keywords

leadership, culture, compassion, nursing, midwifery, managers, cultural competence

Introduction

Leadership in health care is recognized as a necessity to ensure high-quality care, embody support for staff, and establish working environments that prioritize people over rules, regulations, and hierarchies (West et al., 2015). It is argued that compassionate leadership has a positive impact on "patient experience, staff engagement and organisational performance" (Bolden et al., 2019, p. 2). In multicultural societies, cultural competence is a key aspect of leadership, as this is essential in achieving the culturally and

linguistically competent patient services that are necessary to reduce health care inequalities; and because the expression of compassion is culturally mediated, compassionate care must necessarily also be culturally competent. Culturally competent compassion in health care has been defined as

> a 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 both the patients' and the carers' cultural background as well as the context in which care is given (Papadopoulos, 2018, p.2).

Furthermore, culturally competent and virtuous leadership is ethically founded on compassion, honesty, kindness, altruism, and cooperation (Papadopoulos, 2018).

Leadership and compassion are universal concepts. The art of leading people is a basic element in the organization of group activity in any human society (Lewis, 1974). Likewise, the emotional, cognitive, and behavioral responses that arise from empathizing with others' suffering are evolutionarily linked to caregiving for offspring (Preston, 2013). Nevertheless, leadership and compassion are crucially shaped by culture (Chiao, 2017; Koopmann-Holm & Tsai, 2017). They require a complex orchestration of sets of embodied and acquired values in relation to emotional experience and expression, power, social norms, and morality—which all pertain to distinct cultural self-definitions (Kitayama, 2002).

Available evidence on the interplay between culture and leadership has mainly built on theorizing by Triandis (1988) and Hofstede (1984). The constructs of individualistic and collectivist cultures remain relevant and have benefited from a number of refinements, for example, the qualification of horizontal and vertical individualism and collectivism to account for the level of acceptance of social hierarchy (Singelis et al., 2016); and the formulation of loose and tight cultures, which captures the level of rigidity of social norms (Gelfand et al., 2011). In the largest study on culture and leadership, the GLOBE study, several dimensions are combined to identify cultural clusters correlating with leadership styles, such as team-oriented, participative, autonomous, and humane (Dorfman et al., 2004). The humane leadership style is based on compassion, generosity, and concern for others' well-being (Kabasakal & Bodur, 2004). Building on the GLOBE's results, it has been maintained that the humane leadership style is a universal style, rather than specific to Western cultural milieu. In fact, similar cultural concepts from Africa (e.g., Ubuntu and Harambee), and main religious traditions, such as Hinduism and Judaism, have been identified (Winston & Ryan, 2008). Other scholars have shown instead how humane leadership style varies a great deal from one country to another. Schloesser et al. (2012), for example, found that the humane leadership construct appeared to negatively correlate with countries' welfare state but positively correlate with the value of agreeableness in a country.

Culture plays an important role in how compassion, as an emotional or cognitive process, is experienced and expressed, and in which supportive behaviors it should

[1]Middlesex University, London, UK
[2]Western Sussex Hospitals NHS Foundation Trust, Worthing, UK
[3]Walden University, Minneapolis, MN, USA
[4]Istanbul Sabahattin Zaim University, Istanbul, Turkey
[5]VID Specialized University, Oslo, Norway
[6]University of West Attica, Athens, Greece
[7]Universidad Diego Portales, Santiago, Chile
[8]Bataan Peninsula State University, Bataan, Philippines
[9]University of Haifa, Haifa, Israel
[10]Universidad Autónoma de Madrid, Madrid, Spain
[11]Cyprus University of Technology, Limassol, Cyprus
[12]School of Nursing, Havlíčkův Brod, Czech Republic
[13]Stanisław Staszic State University of Applied Science, Pila, Poland
[14]Constantine the Philosopher University in Nitra, Nitra, Slovak Republic
[15]Universidad Nacional de Colombia, Bogotá, Colombia
[16]University of Thessaly, Larissa, Greece
[17]Gerencia Asistencial de Atención Primaria, Servicio Madrileño de Salud, Madrid, Spain
[18]Rzeszów University, Rzeszów, Poland
[19]University of Johannesburg, Johannesburg, South Africa
[20]Wolfson Medical Center, Holon, Israel
[21]Oslo Metropolitan University, Oslo, Norway
[22]Near East University, Nicosia, Cyprus
[23]University of Debrecen, Debrecen, Hungary
[24]Research, Clinic and Care Organization Innovation "Luisa Marano" Area. UOC Care to the person, ASL Roma 2, Rome, Italy
[25]University of South Bohemia in České Budějovice, České Budějovice, Czech Republic
[26]Eastern Mediterranean University, Famagusta, Cyprus

Corresponding Author:
Irena Papadopoulos, PhD, RM, RN, FHEA, Head, Research Centre for Transcultural Studies in Health, Department of Mental Health and Social Work, School of Health and Education, Middlesex University, The Burroughs, London NW4 4BT, UK.
Email: r.papadopoulos@mdx.ac.uk

result (Koopmann-Holm & Tsai, 2017). Levine et al. (2001) conducted a study in 23 nations to examine how people responded to strangers needing help. They found that the Latino cultural script of *simpatia*—a concept assimilable to compassion and humanness—positively correlated with helping behavior. Advances in cultural neurosciences have shown that the experience of vicariously feeling others' suffering can be modulated by cultural values (Chiao, 2017). In this sense, Cheon et al. (2011) demonstrated that in-group empathy is generally higher in hierarchical cultures, like the Korean one, than in egalitarian contexts, like the North American.

Finally, the transcultural concept of emotion, including empathy which is an important component of compassion, has been elaborated in cultural and psychological anthropology. Work conducted among peoples in the Pacific areas argued that emotions are not universal, but rather embedded into specific sociocultural processes (Lutz, 1988). Other studies have focused on the appropriateness of empathy in societies (e.g., Micronesian and Mayan) where secrecy and privacy are highly valued, and where empathic-like knowledge of others can be perceived as intrusion or attack (Groark, 2008).

Compassionate leadership has been increasingly studied and promoted in the health care sector (Papadopoulos, 2018; Martin & Heineberg, 2017; Worline & Dutton, 2017). The development of a Compassionate Leader Behavior Index (Shuck et al., 2019) is a recent advance in understanding and measuring compassionate leadership, but like much of the evidence discussed above, this does not deepen the cultural determinants of compassionate leadership, and how these affect culturally competent and compassionate leadership. Questions remain around how conceptions and behaviors associated with both leadership and compassion are held and expressed by people with different cultural backgrounds in their local worlds. Making sense of culture in compassionate leadership can also facilitate the use of culturally competent practice in health care, rooted in cultural awareness, sensitivity, and knowledge (Papadopoulos, 2006).

This article builds on the only model that includes the impact of culture in compassion-giving in health care (Papadopoulos, 2018). According to this model, specific characteristics of cultures are the result of environmental factors (place), historical factors (time), people's existing values (socialization), and other unique factors, such as political and economic systems, group/ethnic conflict, and education, which will affect how compassion is understood and enacted. It could be argued that these characteristics form the collective programming of the mind that distinguishes the members of one group or category of people from others, which is how culture has been defined by Hofstede et al. (2010).

Research into the role of culture and the fostering of culturally competent and compassionate leadership in health care is at an embryonic stage. In this project, we acknowledge that the participants from each country may be a mixture of native and immigrant people. It has become apparent that global mobility of health professionals has resulted in multiethnic/multicultural workforces. This poses a challenge for those researching culture at an international level. For example, in our study, participants from the United Kingdom described themselves as Asian, Australian, Black Caribbean, British, Indian, Irish, or Japanese American. However, we also need to acknowledge that migrant health care workers over time adopt the organizational culture, and they also acculturate to the national culture of their host country. Due to these challenges, this study adopts the Hofstede et al. (2010) notion of national cultural identity.

Aims

This article focuses on the following three questions: (1) "How do you define compassion?" (2) "Can you list the advantages of giving compassion to staff?" and (3) "Can you explain why receiving compassion is important to you?" Participants were invited to provide examples from their own working environments in order to underpin their responses. Furthermore, this article aspires to contribute to the notion of culturally competent and compassionate leadership; therefore, the findings are discussed taking into account the participating countries' culture and how this may influence the participants' views about compassionate leadership.

Method

The design of this study is an exploratory, cross-sectional, descriptive, online survey using closed and open-ended questions. The full questionnaire is publicly available online from the research center website at www.cultureandcompassion.com/victcory/international-on-line-compassion-survey (Papadopoulos, 2019).

Sample and Data Collection

A snowball sampling method was used resulting in the selection of an international convenience sample of nursing and midwifery managers (total $N = 1,217$ across 17 countries). The demographic characteristics of the sample are presented in Table 1. Of the 17 countries, nine were from the European region (57% of whole sample), and of these, four consisted of Eastern European countries; four countries belonged to the Middle East region, and three from the Americas—of which two were from South America. One African country was represented. The main inclusion criterion was being a nurse or a midwife manager in a hospital, community, or educational setting. Data collection occurred between the end of November 2017 and the end of July 2018. Data were collected using the web-based electronic survey software *Qualtrics*. International research partners

Table 1. Key Characteristics of Participants From the 17 Participating Countries (Total N = 1,217).

Country	n	%	Gender	Profession	Years of management experience	Number of people managed	Work setting
1. Spain	124	10.2	F: 101 M: 23	Nursing: 118 Midwifery: 3 Other: 3	1-5 years: 46 6-10 years: 28 >11 years: 50	1-5 p: 10 6-10 p: 7 11-20 p: 33 21-50 p: 34 >51 p: 40	Hospital: 56 Education: 5 Community/ primary care: 61 Other: 2
2. Slovakia	106	8.7	F: 102 M: 4	Nursing: 100 Midwifery: 6	1-5 years: 67 6-10 years: 21 >11 years: 18	1-5 p : 43 6-10 p: 23 11-20 p: 27 21-50 p: 6 >51 p: 7	Hospital: 75 Education: 22 Community/ primary care: 9
3. Poland	95	7.8	F: 89 M: 6	Nursing: 84 Midwifery: 10 Other: 1	1-5 years: 27 6-10 years: 23 >11 years: 45	1-5 p: 14 6-10 p: 15 11-20 p: 32 21-50 p: 20 >51 p: 14	Hospital: 70 Education: 11 Community/ primary care: 13 Other: 1
4. Israel	75	6.2	F: 69 M: 6	Nursing: 43 Midwifery: 5 Other: 27	1-5 years: 22 6-10 years: 13 >11 years: 40	1-5 p: 21 6-10 p: 6 11-20 p: 17 21-50 p: 19 >51 p: 12	Hospital: 35 Education: 28 Community/ primary care: 5 Other: 7
5. Czech Republic	74	6.1	F: 73 M: 1	Nursing: 63 Midwifery: 5 Other: 6	1-5 years: 18 6-10 years: 17 >11 years: 39	1-5 p: 2 6-10 p: 11 11-20 p: 21 21-50 p: 22 >51 p: 18	Hospital: 74
6.a Cyprus (Turkish speaking)	73	6.0	F: 73	Nursing: 73	1-5 years: 6 6-10 years:28 >11 years: 39	1-5 p: 5 11-20 p: 64 21-50 p: 4	Hospital: 72 Education: 1
6.b Cyprus (Greek speaking)	47	3.9	F: 33 M: 14	Nursing: 40 Midwifery: 4 Other: 3	1-5 years: 14 6-10 years: 13 >11 years: 20	1-5 p: 15 6-10 p: 3 11-20 p: 9 21-50 p: 10 >51 p: 10	Hospital: 19 Education: 12 Community/ primary care: 13 Other: 3
7. Chile	72	5.9	F: 69 M: 3	Nursing: 62 Midwifery: 9 Other: 1	1-5 years: 24 6-10 years: 20 >11 years: 28	1-5 p: 18 6-10 p: 18 11-20 p: 7 21-50 p: 11 >51 p: 18	Hospital: 23 Education: 17 Community/ primary care: 25 Other: 7
8. Hungary	71	5.8	F: 5 M: 64 Other: 2	Nursing: 50 Midwifery: 3 Other: 18	1-5 years: 19 6-10 years: 19 >11 years: 33	1-5 p: 4 6-10 p: 13 11-20 p: 16 21-50 p : 24 >51 p: 14	Hospital: 60 Education: 3 Community/ primary care: 7 Other: 1
9. Colombia	69	5.7	F: 62 M: 7	Nursing: 64 Midwifery: 2 Other: 3	1-5 years: 21 6-10 years: 19 >11 years: 29	1-5 p: 17 6-10 p: 10 11-20 p: 7 21-50 p : 15 >51 p: 20	Hospital: 36 Education: 21 Community/ primary care: 6 Other: 6
10. Norway	63	5.2	F: 53 M: 10	Nursing: 57 Other: 6	1-5 years: 21 6-10 years: 15 >11 years: 27	6-10 p: 2 11-20 p: 4 21-50 p: 32 >51 p: 25	Hospital: 45 Education: 1 Community/ primary care: 17

(continued)

Table 1. (continued)

Country	n	%	Gender	Profession	Years of management experience	Number of people managed	Work setting
11. Greece	58	4.8	F: 50 M: 8	Nursing: 58	1-5 years: 26 6-10 years: 15 >11 years: 17	1-5 p: 5 6-10 p: 15 11-20 p: 23 21-50 p: 4 >51 p: 11	Hospital: 52 Education: 4 Community/ primary care: 1 Other: 1
12. The United Kingdom	53	4.4	F: 48 M: 5	Nursing: 27 Midwifery: 23 Other: 3	1-5 years: 16 6-10 years: 20 >11 years: 17	1-5 p: 14 6-10 p: 12 11-20 p: 11 21-50 p: 9 >51 p: 7	Hospital: 35 Education:9 Community/ primary care: 9
13. Turkey	52	4.3	F: 49 M: 3	Nursing: 45 Midwifery: 2 Other: 5	1-5 years: 20 6-10 years: 20 >11 years: 12	1-5 p: 1 6-10 p: 7 11-20 p: 17 21-50 p: 13 >51 p: 14	Hospital: 50 Education: 2
14. Philippines	49	4.0	F: 32 M: 17	Nursing: 47 Midwifery: 1 Other: 1	1-5 years: 25 6-10 years: 16 >11 years: 8	1-5 p: 6 6-10 p: 9 11-20 p: 12 21-50 p: 12 >51 p: 10	Hospital: 33 Education: 9 Community/ primary care: 5 Other: 2
15. Italy	48	3.9	F: 36 M: 12	Nursing: 44 Midwifery: 1 Other: 3	1-5 years: 4 6-10 years: 10 >11 years: 34	1-5 p: 4 6-10 p: 5 11-20 p: 2 21-50 p: 5 >51 p: 32	Hospital: 23 Education: 16 Community/ primary care: 6 Other: 3
16. South Africa[a]	48	3.9	F: 40 M: 7	Nursing: 33 Midwifery: 12 Other: 3	1-5 years: 12 6-10 years: 13 >11 years: 22	1-5 p: 6 6-10 p: 5 11-20 p: 6 21-50 p: 12 >51 p: 18	Hospital: 15 Education: 25 Community/ primary care: 7 Other: 1
17. The United States	40	3.3	F: 32 M: 8	Nursing: 38 Midwifery: 2	1-5 years: 16 6-10 years: 6 >11 years: 18	1-5 p: 6 6-10 p: 5 11-20 p: 3 21-50 p: 7 >51 p: 19	Hospital: 29 Education: 4 Community/ primary care: 7
Total	1,217	100.0	F: 1,016 M: 198 Other: 2	Nursing: 1,046 Midwifery: 88 Other: 83	1-5 years: 404 6-10 years: 316 >11 years: 496	1-5 p: 191 6-10 p: 166 11-20 p: 311 21-50 p: 259 >51 p: 289	Hospital: 776 Education: 168 Community/ primary care: 156 Other: 117

Note. F = female, M = male, p = people.
[a]Missing one value for gender, years of experience, and number of people managed.

circulated the invitation letter containing the link to the questionnaire to colleagues. A minimum of 40 responses were to be collected from each country for it to be included in the final sample.

Data Analysis

A directed hybrid approach of inductive and deductive thematic analysis was employed to analyze the responses to the selected open-ended questions (Fereday & Muir-Cochrane, 2006). This involved examining the survey responses line-by-line and grouping them into categories and themes, as described in Braun and Clarke (2006), with one researcher examining and coding, for several rounds of reviewing and refining the themes. Coding was discussed with the principal investigator during team meetings. In addition, a coding manual was produced providing a detailed audit trail of the process. The entire analysis was supported by NVivo Version 12 software.

Rigor

Several steps were taken to ensure the quality of the methods used in this study. First, survey questions were checked for

clarity by members of the international team, and problems with translation that were detected were resolved. Second, the translation and back translation into English of the survey questionnaire, the invitation letter, and the qualitative data collected followed the World Health Organization guidelines (2016). The lead researcher had the responsibility to create the links to the online survey for each country, and all data were sent to the lead researcher for analysis. Methodological rigor in the analysis was also enhanced by involving several members of the U.K. research team in coding some of the raw data from one or two countries, and by regular team discussions.

Ethical Considerations

The study was approved by the Health and Social Care ethics subcommittee (No. 1477) of the School of Health and Education at the lead researcher's university. Additionally, every researcher from all participating countries obtained ethical clearance from their respective university/health care organization authority where required. Potential participants received the link to the survey along with an invitation letter that explained the aim and procedures of the study; that participation was anonymous, confidential, and completely voluntary; and that answering the questions constituted consent to the study.

Results

Four overarching themes were derived from the analysis, and selected subthemes and quotes per each theme are presented in four tables as follows: (1) managers' definitions of compassion (Table 2), (2) advantages and importance of compassion for managers (Table 3), (3) advantages and importance of compassion for staff and the workplace (Table 4), and (4) culturally competent and compassionate leadership (Table 5).

Theme 1: Managers' Definition of Compassion

Participants from all countries associated compassion with a virtuous quality; in particular, it was overwhelmingly associated with humanness. Another common characterization of compassion lies within the relational realm, with most managers highlighting a relationship between compassion, and trust and honesty. When conceived as a feeling or an emotion, compassion was sometimes defined in terms of pity, sadness, and feeling sorry due to empathizing with suffering staff. For some participants, feelings of compassion motivated and triggered helping actions. Some managers viewed compassion as an innate quality, others as something connected to upbringing and experience. Finally, a small proportion of participants defined compassion as inherent in the profession.

Theme 2: Advantages and Importance of Compassion for Managers

The advantages and the importance of compassion for managers were variously expressed by participants. For some, compassion and management are strictly interlinked, and others underline how compassion benefits managers directly, in terms of feeling valued and respected. Other managers emphasized how, by giving compassion to their staff, they in turn received understanding, support, and appreciation. Some participants highlighted the importance of being role models for their staff, and how compassion played an important part in their leadership style.

Theme 3: Advantages and Importance of Compassion for Staff and the Workplace

Manager–staff relationships informed by a compassionate approach become closer, more positive, and open. This results in a virtuous circle whereby compassion feeds into compassion, thus establishing a nurturing, positive environment in which managers are more approachable, staff feel more comfortable, and patients enjoy better care. Enhanced teamwork was also placed among the chief advantages of compassion-giving, because compassion helps foster harmonious, peaceful relationships; good communication; and a participatory, empowering approach in which nurses are listened to. Problem-solving, decision-making, and conflict-resolution were also seen as improving. Better performance and productivity in meeting organizational goals, on the one hand, and the improvement of the quality of care for patients, on the other, were also mentioned. Compassion is overall regarded beneficial for both managers and staff's mental health, improving their professional life quality and satisfaction, while decreasing risk of burnout.

Theme 4: Culturally Competent and Compassionate Leadership

Being available to meet with their staff is an important element found across all countries, according to different leadership styles and to individual and cultural characteristics of members of staff. Advocating for their staff is expressed in terms of protecting them against inappropriate treatment that they may receive from patients or their relatives, and unprofessional treatment from other clinicians. Others expressed an attitude of general advocacy of the nurses' role and their rights, based on knowing the staff and their situations. In countries where managers deal with highly multicultural teams, an open and accommodating attitude toward staff's cultural backgrounds was especially commonly reported, also in relation to child care duties and health. Attention to personal and professional development has emerged in terms of encouraging training and the flourishing of the employee, and finally, a rich set of less tangible attitudes emerged from

Table 2. Theme 1: Managers' Definition of Compassion.

Humanness and trust	Pity and sadness	Helping actions	Innate versus acquired quality, inherent to the profession
"Compassion is humane attention that understands the human nature" (Colombia)	"Like a feeling of sadness for someone who's suffering" (Spain)	"It is not enough for managers to show empathy: in fact, besides understanding our staff, we need to act [. . .] A compassionate manager understands their fatigue and barriers and struggles for a solution" (Turkey)	"You cannot teach someone compassion in a classroom. Compassion can be moulded by maturity and experience as long as some has developed a baseline of compassion during their childhood and adolescent years" (the United Kingdom)
"Being compassionate is an expression of humanity, the proof of the fact that we can understand other people better and sympathise with them" (Slovakia)	"Feelings of piety towards those who in a given period are unhappy; participation in the suffering of others" (Italy)	"Empathize with the mood of the other, empathize and understand the other as s/he is, without wanting to change anything" (Chile)	"Compassion is an expression of the care and love we possess inside" (South Africa)
"Compassion is a manifestation of human feelings towards another human being. I know that I work with people and not with robots" (Poland)			"First and foremost, the very choice of the nursing profession means that I am compassionate towards people. Compassion is an emotional skill, it is the place where there is consideration of the feelings of others" (Israel)
"Compassion is understanding staff needs, feelings, situations and knowing them personally builds relationships which engender trust and loyalty" (the United States)			"The human quality that every health worker has to possess" (Turkey)

the managers' responses, which was expressed in terms of participation, perspective taking, closeness and connection, and interest and active listening.

Discussion

Managers from all the participating countries defined compassion in terms of humanness, speaking to the universal dimension of compassion. The relationship between humane and compassionate health care that the participants expressed parallels conceptions put forward by the academic community (Papadopoulos, 2018; Crowther et al., 2013). In our study, managers from South America and the Philippines—two collectivist cultures, where in-group cohesion and a sense of a shared humanity appear higher (Oyserman et al., 2002)—have overwhelmingly emphasized how compassion pertains to the essence of being human. The attention to a humane approach, also expressed by Central–Eastern European managers can be read against the backdrop of the radical set of reforms in postcommunist health transitions (Safaei, 2012). These reforms have led to greater unemployment and uncertainty in the workplace (Bludau, 2014), and consequently, health care professionals may feel urged to appeal to a sense of humanity.

Compassion has been seen as functional in establishing a trustworthy manager–staff relationship, which was prevalent in the United States. The United States is a predominantly individualistic country, and it is widely accepted that employers focus on productivity and fear of litigation. It has also been reported that health care staff turnover rate has recently been alarmingly high (Nursing Solutions, 2019). These factors may explain managers' desire to establish relationships with their staff which are informed by trust and honesty. On the other hand, the conflating of compassion with sadness and pity (which may or may not lead to supportive action) emerged in countries where traditional Christian Catholic values (e.g., Italy, Spain, and Colombia) are more strongly held.

The positive findings reported in this article could be viewed as a continuum. At one end is the emphasis on the self (the manager), moving through the benefits of compassion for the manager–staff relationship, staff well-being, and teamwork, and, finally, at the other end, are the broader benefits for the work setting. However, according to the culturally competent and virtuous compassion model proposed by Papadopoulos (2018), a number of negative factors can tip this delicate balance and turn the two ends of the continuum into toxic positions, with extreme self-interest/individualism

Table 3. Theme 2: Advantages and Importance of Compassion for Managers.

Compassion and management interlinked	Compassion makes managers feel valued and respected	Compassion makes managers feel supported and appreciated	Role models and leadership style
"I think compassion and management should go hand in hand to facilitate teamwork and reduce psychosocial risks in the workplace" (Colombia)	"In many years of handling personnel under my supervision, kindness and humbleness is what I've shown to them, so I gained respect in return" (Philippines)	"Staff appreciate you more. They can go the extra mile. They feel happier and more satisfied at work" (the United Kingdom)	"I should not always be a boss figure, but act as a leader who they can trust . . . a friend . . . or a mother" (Philippines)
"It is common practice and a basic managerial ability to show employees empathy and compassion" (Norway)	"They love me and respect me, you are not just boss but you are a friend too" (Hungary)	"I get back the support and help from them! When I need it, they also back me up" (Hungary)	"Compassion strengthens positive leadership" (Chile)
"Compassion is a manifestation of human feelings towards another human being. I know that I work with people and not with robots" (Poland)			"Being a good listener, regular meetings, to be hands-on with what staff are doing, to have better understanding of what is done, leadership style" (South Africa)

at one end, and extreme collectivism at the other. Personal and professional pressures on managers can negatively influence their leadership styles resulting in increased self-centeredness or conversely, in creating a very tight collectivist work team, both of which are undesirable states. It is therefore important that managers are supported by their superiors and the staff in their teams to maintain a balanced culturally competent and compassionate leadership style.

Overall, these findings are consistent with findings on compassion satisfaction in nursing (Sacco & Copel, 2018), which alone may be located on the individualistic end of our continuum. In contrast, compassion flow (Tierney et al., 2017) appears to speak more to the collectivist end of the spectrum. The positive effect of compassion-giving to teamwork, which we found to be very prominent, is also consistent with the literature. This speaks to both the notion of "collective capability for compassion" (Lilius, Worline, et al., 2011) and to positive association between compassion-giving and work engagement (De Clercq et al., 2014). Finally, our evidence highlighted the crucial role of managers in establishing culturally competent and compassionate workplace cultures, which undoubtedly can influence the quality of patient care (Beardsmore & McSherry, 2017). Some of the culturally competent components and manifestations of compassion offered by our participants echo the compassion components reported by practicing nurses, such as giving time, being there, defending and advocating, and personalization (Papadopoulos et al., 2016, 2017). This suggests that compassion-giving is not drastically affected by the position one occupies in an organization. The findings reported in this article appear to support Shuck et al.'s (2019) assertion that displaying compassion is not dependent on the traditional leader–follower exchange and may not conform to traditional boundaries.

Cultural anthropologists, while neglecting compassion as such, have investigated the emotions linked to empathy (Hollan & Throop, 2008). Empathy, as compassion, implies a caring, concerned attitude and the acquisition of better understanding of the other—as our respondents have frequently highlighted—and contributes to make it a distinguished way of understansing people (Halpern, 2011). But it is possible for an empathic approach to be maintained even when understanding fails (Kirmayer, 2008), thereby making it a potent tool that can transcend differences in illness experiences, power positions, and cultural backgrounds and norms. If the cultural and political contexts influence the processes of meaning-making and the practices of compassion exchange, forms of caregiving are also transversal and transcultural. Compassion in management is increasingly recognized as a "trans-cultural source of wisdom" (Opdebeeck & Habisch, 2011).

Kleinman (2015) pointed out that "caregiving is relational and reciprocal" and can be conceived anthropologically as a "gift exchange," which is "moral, emotional, and practical" (p. 240). This study is going one step further. Our findings suggest that compassion giving and receiving form a symbiotic transactional relationship, because a compassion giver always receives some compassion back, directly from the receiver or indirectly as self-growth, which may or may not be recognized immediately. Therefore, if compassion in general is viewed as a transactional act, it means that culturally situated, transactional compassion can be a beneficial and potent tool to transcend otherness, and ensure authentic caregiving, at all levels of the organization. The majority of the nursing and midwifery managers participating in this study have shown how compassion relates to the establishment of caring relationships that bear emotional investment and cultural resonance (Jones,

Table 4. Theme 3: Advantages and Importance of Compassion for Staff and the Workplace.

Positive manager–staff relationship	Better teamwork, problem- and conflict-solving	Improved performance and care quality	Improved well-being and risk of burnout reduced
"Showing compassion helps maintain proper interpersonal relations; in the case of nursing staff it strengthens empathic behaviour towards the patients" (Poland)	"Everybody excels in something, and when it is possible, I try to enable them to make use of their knowledge" (Czech Republic)	"Staff [. . .] work harder, with less time off and in a more positive working environment, which clearly will follow on to improved care to patients and their families" (Greek-speaking Cyprus)	"The advantages [of compassion-giving] can be: involvement, motivation, serenity, increased sense of responsibility, positive climate" (Italy)
"By giving compassion, you receive from your staff, quality work/friendship/better collaboration. You build better relation" (Greek-speaking Cyprus)	"[Compassion] helps to make difficult decisions. Reduces conflict. Improves the work environment. Encourages relationships and teamwork" (Spain)	"Creating understanding, reinforcing the relationship and enhancing the employee's commitment to the organization" (Israel)	"I think that compassion leads to confidence and a greater work satisfaction" (Norway)
"I am convinced that compassion is a contagious sentiment that spreads around everybody if the manager has it" (Italy)	"I think compassion will increase peace at workplace. We will feel happier" (Turkish-speaking Cyprus)		"Compassion can help tackle psychological problems that the nurses feel, like fatigue and stress" (Turkish-speaking Cyprus)
"Compassion generates an environment of trust and human warmth" (Colombia)			
"Trying to use individual qualities and culture to the best of the unit. At the same time, I wish to have a common culture in the unit" (Norway)			

2005), as well as compassionate workplaces characterized by a focus on care, instead of productivity, and by flourishing relationships and collaborations. Transactional culturally competent compassion—as a quintessential nursing quality—sits at the core of transcultural nursing, and possibly even more poignantly with nursing and midwifery managers, who—as leaders—are particularly called on to be able to transculturally resonate with their staff and patients, organizational pressures, and national/global trends. Therefore, along with the novel conceptualization of compassion as a transactional act, this article also revitalizes the established idea of compassion as a potentially universal humane *and* professional tool that needs to be inseparable from cultural competence (Papadopoulos, 2006).

Strengths and Limitations

To our knowledge, this is the only qualitative exploration of how nursing and midwifery managers view, define, recognize, and practice culturally competent compassion (with a particular focus on the importance and advantages of compassion-giving). Also unique is the study's secondary goal of improving our understanding around cultural determinants of compassion-giving among nursing and midwifery managers (which is reflected in the participatory,

transnational design of the survey). Partners are pursuing further analysis of their own country's data, with rich culturally and structurally situated analyses. This study is also of exceptional diachronic value as it constitutes a further tile (the first one being the previous international survey among nurses) in the construction of a broader theory of culturally competent *and* compassionate care, and how it can be studied. The study was also careful to incorporate a number of systematic measures to reduce bias in its analysis, such as adopting a hybrid approach, following systematic steps, and involving several researchers in the data analysis, which provided the necessary verification of the findings.

Regarding the study's limitations, we acknowledge that the selection of the countries involved was dictated by the network of the coordinating U.K. research team, which accounts for the Eurocentric bias of the sample. The online survey design prevented the collection of empirical contextual data, and practical constraints limited the use of the literature in country languages. Due to the challenges that exist in the unravelling of the cultural values of participants in international studies, and our adoption of national cultures in the interpretation of this study's data, our contribution to understanding how cultures inform compassion-giving should be viewed with caution.

Table 5. Theme 4: Culturally Competent and Compassionate Leadership.

Open and flexible to meet with staff	Advocacy and protection	Accommodating attitude towards staff's cultural backgrounds and needs	Encourage PPD and participation
"With intergenerational/cultural management, staff have different preferences: some only text, some only accept calls, some never check emails, some don't like to speak in person, if it could be an email" (the United States)	"Generally, our staff members get verbally abused by the patients or their relatives. At such times as a manager I never hesitate to call the security or police [. . .] I feel like I have to protect my staff" (Turkish-speaking Cyprus)	"A Druze nurse lives in a distant village. It is difficult for her to do an evening shift (since her community does not view her late arrival in the village favourably) [. . .] I try as much as possible to allow each ethnic group to celebrate their holidays with their families" (Israel)	"Work tasks correspond to competence, interdisciplinary concerns; make competence visible, areas and jobs that are appropriate" (Norway)
"[Giving compassion] On day shifts, evening shifts, when I attend doctor's round, having an open door, having time, put other work aside when there is need for a conversation" (Norway)	"I try to prevent the physicians from offloading their work on the nurses" (Czech Republic)	"If a Muslim staff member requires days off for religious holidays, I encourage that. Likewise if a Black African staff member requests time off to attend special ceremonies, I encourage that" (South Africa)	"Praise successes. Focus on strengths and positive qualities" (the United Kingdom)
"I am convinced that compassion is a contagious sentiment that spreads around everybody if the manager has it" (Italy)	"The defence of the rights of the personnel is done via an absence of prejudices, an in-depth knowledge of the situations, also the knowledge of the characteristics of the staff in charge" (Colombia)	"I try to engage about their countries, how midwifery differs [. . .] They often have a very different perspective about UK culture, how they perceive it so we have interesting mind-opening conversations" (the United Kingdom)	"Understanding the deeper problems of the member of staff with an emotional way of resolving them" (Greece)
"Compassion generates an environment of trust and human warmth" (Colombia)	"If I have opportunities, I always stand by their side" (Poland)	"Sometimes we have to bend or maybe try to 'be in their culture' without jeopardizing our own" (Philippines)	"Cry with the crying, laugh with the laughing, and do not think you're better than them" (Czech Republic)
"Trying to use individual qualities and culture to the best of the unit. At the same time, I wish to have a common culture in the unit" (Norway)		"I work in hospice, and culture can greatly affect how we view death and dying" (the United States)	"We have a multicultural and multinational nursing team. I try to encourage everyone within the team to do more listening rather than talking" (Greek-speaking Cyprus)
		"I am in charge of nurses from indigenous communities with particular characteristics which I must respect" (Colombia)	

Note. PPD = personal and professional development.

Conclusion

The study of the generic and specific country cultural determinants affecting the views of compassionate leadership in health care needs expansion. Leaders sit at the intersection of multiple pressures and are required to *transculturally* resonate with their staff and patients, within complex sets of intersubjective contacts, organizational pressures, and national/global forces. The value placed on compassion by our participants has several implications:

- *Cultural values and leadership*: Culturally intelligent (Rockstuhl et al., 2011) and compassionate leaders should have deep awareness of their own cultural values to account for the influence of their own culture on their leadership styles. Transcultural models and practices of ethical leadership (Eisenbeiß & Brodbeck, 2014) should be developed to establish nurturing health care working environments from which all stakeholders can benefit. Culturally specific models of leadership are to be framed within the pillars of transcultural and compassionate nursing, which are ethics, intercultural relations, sociopolitical systems, and human rights (Papadopoulos, 2006).
- *Building compassion into organizations*: Strategies for developing culturally competent and compassionate health care leadership require a shift from the prevalent dehumanizing model of the organization as machine to a model of the organization as a complex and interconnected adaptive living system. An effort to "institutionalise compassion" (Lilius, Kanov, et al., 2011) and cultural competence should be adopted throughout the organization with collective holistic learning strategies and high levels of staff support and engagement.
- *The role of self-compassion*: Providing training in coping and self-compassion strategies is an overdue imperative that will encourage nursing and midwifery managers to show compassion and to nurture the values that underpin professional codes of practice. The organization of transnational peer group events as occasion to reflect, self-help, and define good practices should be fostered.

An innovative research agenda in this field should pursue further multidisciplinary and local empirical research, with transnational collaborations. Finally, while always culturally situated, transactional compassion can be a potent tool to transcend otherness, and ensure authentic caregiving, at all levels of the organization.

Ethical Approval

The study was approved by the Health and Social Care ethics sub-committee (No. 1477) of the School of Health and Education at the lead researcher's university.

ORCID iDs

Runa Lazzarino https://orcid.org/0000-0002-4206-4913
Magdeline Aagard https://orcid.org/0000-0002-4394-1842
Orit Eldar-Regev https://orcid.org/0000-0002-5397-5210
Mara Muñoz-Solinas https://orcid.org/0000-0001-9260-9021
Sara Nissim https://orcid.org/0000-0001-8381-8104
Cristina Oter-Quintana https://orcid.org/0000-0002-2192-5120

References

Beardsmore, E., & McSherry, R. (2017). Healthcare workers' perceptions of organisational culture and the impact on the delivery of compassionate quality care. *Journal of Research in Nursing*, *22*(1-2), 42-56. https://doi.org/10.1177/1744987116685594

Bludau, H. (2014). The power of protocol: Professional identity development and governmentality in post-socialist health care. *Sociologický Časopis/Czech Sociological Review*, *50*(6), 875-896. https://doi.org/10.13060/00380288.2014.50.6.145

Bolden, R., Adelaine, A., Warren, S., Gulati, A., Conley, H., & Jarvis, C. (2019). *Inclusion: The DNA of leadership and change*. https://uwe-repository.worktribe.com/output/852067

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Cheon, B. K., Im, D.-M., Harada, T., Kim, J.-S., Mathur, V. A., Scimeca, J. M., Parrish, T. B., Park, H. W., & Chiao, J. Y. (2011). Cultural influences on neural basis of intergroup empathy.

NeuroImage, *57*(2), 642-650. https://doi.org/10.1016/j.neuroimage.2011.04.031

Chiao, J. Y. (2017). Cultural neuroscience of compassion and empathy. In E. M. Seppälä, E. Simon-Thomas, S. L. Brown, M. C. Worline, C. D. Cameron, & J. R. Doty (Eds.), *The Oxford handbook of compassion science* (pp. 147-158). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190464684.013.12

Crowther, J., Wilson, K. C., Horton, S., & Lloyd-Williams, M. (2013). Compassion in healthcare: Lessons from a qualitative study of the end of life care of people with dementia. *Journal of the Royal Society of Medicine*, *106*(12), 492-497. https://doi.org/10.1177/0141076813503593

De Clercq, D., Bouckenooghe, D., Raja, U., & Matsyborska, G. (2014). Servant leadership and work engagement: The contingency effects of leader-follower social capital. *Human Resource Development Quarterly*, *25*(2), 183-212. https://doi.org/10.1002/hrdq.21185

Dorfman, P. W., Hanges, P. J., & Brodbeck, F. C. (2004). Leadership and cultural variation. In R. J. House, P. J. Hanges, M. Javidan, P. W. Dorfman, & V. Gupta (Eds.), *Culture, leadership, and organizations: The GLOBE study of 62 societies* (1st ed., pp. 669-719). Sage.

Eisenbeiß, S. A., & Brodbeck, F. (2014). Ethical and unethical leadership: A cross-cultural and cross-sectoral analysis. *Journal of Business Ethics*, *122*(2), 343-359. https://doi.org/10.1007/s10551-013-1740-0

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80-92. https://doi.org/10.1177/160940690600500107

Gelfand, M. J., Raver, J. L., Nishii, L., Leslie, L. M., Lun, J., Lim, B. C., Duan, L., Almaliach, A., Ang, S., Arnadottir, J., Aycan, Z., Boehnke, K., Boski, P., Cabecinhas, R., Chan, D., Chhokar, J., D'Amato, A., Ferrer, M., Fischlmayr, I. C., . . . Yamaguchi, S. (2011). Differences between tight and loose cultures: A 33-nation study. *Science*, *332*(6033), 1100-1104. https://doi.org/10.1126/science.1197754

Groark, K. P. (2008). Social opacity and the dynamics of empathic in-sight among the Tzotzil Maya of Chiapas, Mexico. *Ethos*, *36*(4), 427-448. https://doi.org/10.1111/j.1548-1352.2008.00025.x

Halpern, J. (2011). *From detached concern to empathy: Humanizing medical practice* (1st ed.). Oxford University Press.

Hofstede, G. (1984). *Culture's consequences: International differences in work-related values*. Sage.

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: Software of the mind* (3rd ed.). McGraw-Hill Professional.

Hollan, D., & Throop, C. J. (2008). Whatever happened to empathy? Introduction. *Ethos*, *36*(4), 385-401. https://doi.org/10.1111/j.1548-1352.2008.00023.x

Jones, A. M. (2005). The anthropology of leadership: Culture and corporate leadership in the American South. *Leadership*, *1*(3), 259-278. https://doi.org/10.1177/1742715005054437

Kabasakal, H., & Bodur, M. (2004). Humane orientation in societies, organizations, and leader attributes. In R. J. House, P. J. Hanges, M. Javidan, P. W. Dorfman, & V. Gupta (Eds.), *Culture, leadership, and organizations: The GLOBE study of 62 societies* (1st ed., pp. 564-601). Sage.

Kirmayer, L. J. (2008). Empathy and alterity in cultural psychiatry. *Ethos*, *36*(4), 457-474. https://doi.org/10.1111/j.1548-1352.2008.00027.x

Kitayama, S. (2002). Culture and basic psychological processes: Toward a system view of culture: Comment on Oyserman et al. (2002). *Psychological Bulletin*, *128*(1), 89-96. https://doi.org/10.1037/0033-2909.128.1.89

Kleinman, A. (2015). Care: In search of a health agenda. *Lancet*, *386*(9990), 240-241. https://doi.org/10.1016/S0140-6736(15)61271-5

Koopmann-Holm, B., & Tsai, J. L. (2017). The cultural shaping of compassion. In E. M. Seppälä, E. Simon-Thomas, S. L. Brown, M. C. Worline, C. D. Cameron, & J. R. Doty (Eds.), *Oxford handbook of compassion science* (pp. 273-285). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190464684.013.21

Levine, R. V., Norenzayan, A., & Philbrick, K. (2001). Cross-cultural differences in helping strangers. *Journal of Cross-Cultural Psychology*, *32*(5), 543-560. https://doi.org/10.1177/0022022101032005002

Lewis, H. S. (1974). *Leaders and followers: Some anthropological perspectives*. Addison-Wesley.

Lilius, J. M., Kanov, J. M., Dutton, J. E., Worline, M. C., & Maitlis, S. (2011). Compassion revealed: What we know about compassion at work (and where we need to know more). In G. M. Spreitzer & K. S. Cameron (Eds.), *The Oxford handbook of positive organizational scholarship* (pp. 273-287). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199734610.001.0001

Lilius, J. M., Worline, M., Dutton, J., Kanov, J., & Maitlis, S. (2011). Understanding compassion capability. *Human Relations*, *64*(7), 873-899. https://doi.org/10.1177/0018726710396250

Lutz, C. A. A. (1988). *Unnatural emotions: Everyday sentiments on a Micronesian atoll and their challenge to Western theory* (1st ed.). University of Chicago Press.

Martin, D., & Heineberg, Y. (2017). Positive leadership, power and compassion. In P. Gilbert (Ed.), *Compassion* (1st ed., pp. 221-236). Routledge. https://doi.org/10.4324/9781315564296-13

Nursing Solutions, Inc. (2019). *2019 National Health Care Retention & RN Staffing Report*. https://www.nsinursingsolutions.com/Library.php

Opdebeeck, H., & Habisch, A. (2011). Compassion: Chinese and western perspectives on practical wisdom in management. *Journal of Management Development*, *30*(7/8), 778-788. https://doi.org/10.1108/02621711111150272

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin*, *128*(1), 3-72. https://doi.org/10.1037/0033-2909.128.1.3

Papadopoulos, I. (2018). *Culturally competent compassion*. Routledge.

Papadopoulos, I. (Ed.). (2006). *Transcultural health and social care: Development of culturally competent practitioners* (1st ed.). Churchill Livingstone.

Papadopoulos, I. (2019). *International online surveys: Culturally competent compassion in nursing managers*. https://cultureandcompassion.com/victcory/international-on-line-compassion-survey

Papadopoulos, I., Taylor, G., Ali, S., Aagard, M., Akman, O., Alpers, L.-M., Apostolara, P., Biglete-Pangilinan, S., Biles,

J., García, Á. M., González-Gil, T., Koulouglioti, C., Kouta, C., Krepinska, R., Kumar, B. N., Lesińska-Sawicka, M., Diaz, A. L. L., Malliarou, M., Nagórska, M., … Zorba, A. (2017). Exploring nurses' meaning and experiences of compassion: an international online survey involving 15 countries. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *28*(3), 286–295. https://doi.org/10.1177/1043659615624740

Papadopoulos, I., Zorba, A., Koulouglioti, C., Ali, S., Aagard, M., Akman, O., Alpers, L.-M., Apostolara, P., Biles, J., Martín-García, Á., González-Gil, T., Kouta, C., Krepinska, R., Kumar, B. N., Lesińska-Sawicka, M., Lopez, L., Malliarou, M., Nagórska, M., Nissim, S., … Vasiliou, M. (2016). International study on nurses' views and experiences of compassion. *International Nursing Review*, *63*(3), 395–405. https://doi.org/10.1111/inr.12298

Preston, S. D. (2013). The origins of altruism in offspring care. *Psychological Bulletin*, *139*(6), 1305-1341. https://doi.org/10.1037/a0031755

Rockstuhl, T., Seiler, S., Ang, S., Van Dyne, L., & Annen, H. (2011). Beyond general intelligence (IQ) and emotional intelligence (EQ): The role of cultural intelligence (CQ) on cross-border leadership effectiveness in a globalized world. *Journal of Social Issues*, *67*(4), 825-840. https://doi.org/10.1111/j.1540-4560.2011.01730.x

Sacco, T. L., & Copel, L. C. (2018). Compassion satisfaction: A concept analysis in nursing. *Nursing Forum*, *53*(1), 76-83. https://doi.org/10.1111/nuf.12213

Safaei, J. (2012). Post-communist health transitions in Central and Eastern Europe. *Economics Research International*, *2012*, Article 137412. https://doi.org/10.1155/2012/137412

Schloesser, O., Frese, M., Heintze, A.-M., Al-Najjar, M., Arciszewski, T., Besevegis, E., Bishop, G., Bonnes, M., & Clegg, C. (2012). Humane orientation as a new cultural dimension of the GLOBE project: A validation study of the GLOBE scale and out-group humane orientation in 25 countries. *Journal of Cross-Cultural Psychology*, *44*(4), 535-551. https://doi.org/10.1177%2F0022022112465671

Shuck, B., Alagaraja, M., Immekus, J., Cumberland, D., & Honeycutt-Elliott, M. (2019). Does compassion matter in leadership? A two-stage sequential equal status mixed method exploratory study of compassionate leader behavior and connections to performance in human resource development. *Human Resource Development Quarterly*, *30*(4), 537-564. https://doi.org/10.1002/hrdq.21369

Singelis, T. M., Triandis, H. C., Bhawuk, D. P. S., & Gelfand, M. J. (2016). Horizontal and vertical dimensions of individualism and collectivism: A theoretical and measurement refinement. *Cross-Cultural Research*, *29*(3), 240-275. https://doi.org/10.1177/106939719502900302

Tierney, S., Seers, K., Tutton, E., & Reeve, J. (2017). Enabling the flow of compassionate care: A grounded theory study. *BMC Health Services Research*, *17*(1), Article 174. https://doi.org/10.1186/s12913-017-2120-8

Triandis, H. (1988). Collectivism v. individualism: A reconceptualisation of a basic concept in cross-cultural social psychology. In G. K. Verma & C. Bagley (Eds.), *Cross-cultural studies of personality, attitudes and cognition* (pp. 60-95). Palgrave Macmillan. https://doi.org/10.1007/978-1-349-08120-2_3

West, M. A., Armit, K., Loewenthal, L., Eckert, R., West, T., & Lee, A. (2015). *Leadership and leadership development in health care: The evidence base*. The King's Fund, Faculty of Medical Leadership and Management, Center for Creative Leadership. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

Winston, B. E., & Ryan, B. (2008). Servant leadership as a humane orientation: Using the GLOBE Study construct of humane orientation to show that servant leadership is more global than Western. *International Journal of Leadership Studies*, *3*(2), 212-222.

World Health Organization. (2016). *Process of translation and adaptation of instruments*. https://www.who.int/substance_abuse/research_tools/translation/en/

Worline, M. C., & Dutton, J. E. (2017). How leaders shape compassion processes in organizations. In E. M. Seppälä, E. Simon-Thomas, S. L. Brown, M. C. Worline, C. D. Cameron, & J. R. Doty (Eds.), *The Oxford handbook of compassion science* (pp. 435-456). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190464684.013.31