Organizing compassionate care with compassionate leadership

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Compassion, suffering, leadership, organization, healthcare.

Healthcare is overrepresented in co-worker and manager bullying, undermining the quality of patient care and health outcomes. One cause identified in reviews undertaken within the UK's National Health Service (NHS) is a lack of compassionate leadership. Compassionate leadership is described as a process of *noticing, empathising, appraising* and *responding* (NEAR) to the suffering of others. Workplace compassion has been identified as enhancing employees physical and emotional wellbeing, social relations and individual-organizational performance. In healthcare compassionate leadership is associated with enhanced patient care outcomes. Research on compassionate leadership is in its infancy. Viewing compassionate leadership through the theoretical lens of power, paradox and conservation of resources offers nuanced insights.

Learning Objectives:

1. Define compassionate leadership and its implications for healthcare practice
2. Contrast healthcare delivery supported by compassionate leadership as compared to the toxic healthcare environment that arises in its absence
3. Reflect on examples of efforts to promote compassionate leadership in the UK's NHS
4. Advance a research agenda by considering the implications of different theoretical lenses (power, paradox, conservation of resources) for compassionate leadership research and practice.

Introduction

The aim of this chapter is to provide an account of the significance of compassionate leadership for healthcare practice. Compassionate leadership can be defined as a process wherein a leader *Notices* signs of suffering in their reports, *Empathises* with it, *Appraises* the suffering to understand its

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circumstances and *Responds* to address it (NEAR) (Simpson, 2021; de Zulueta, 2016; West, 2021). The UK's National Health System (NHS) and the effects of the COVID-19 pandemic provide a context for our discussion. Generalising from this context, we hold that the issues considered here are relevant more broadly to healthcare systems across the world even outside of the pandemic context. Research on the effects of COVID-19 on NHS staff suggests a view that "the pandemic had exposed a deficit of 'softer' people skills" in NHS managers (Soundry, 2020: 2-3). It has been further identified that to date "leadership development programmes often neglected the tools and techniques that managers needed to identify, address and resolve challenging people issues." The NHS has been seeking to address these concerns at a national level by investing more resources in staff occupational health and wellbeing, equality and diversity initiatives, working closely with the unions and improved communications to ensure employee voice and engagement (Soundry, 2020).

The experience of COVID-19 has reinforced changing leadership expectations in healthcare that were developing in the even before COVID, where there were growing calls for compassionate leadership that is less concerned with efficiency and budgets and more concerned with the resilience and wellbeing of those impacted by leadership decisions (Vogus and McClelland, 2020). COVID-19 has precipitated a shift in power relations in working lives, making the usually invisible-labour of minimum wage and casual (including in healthcare) workers more visible as 'essential workers' (Lancet, 2020). For the NHS the disruption imposed by COVID-19 has been seen to represent "a limited window of opportunity" for developing "improved communication, greater organizational agility, creative use of new technology, enhanced employee voice and deeper stakeholder partnerships" (Soundry, 2020: 2-3). Bringing in a new working environment advancing compassionate leadership requires reimagining leadership as a co-created enactment reducing power distance by advancing inclusiveness, dialogue and feedback loops. We explore some of these implications in this chapter.

We structure the chapter by initially providing a background of the general poor work culture often found in the UK NHS (and healthcare more broadly even outside of the UK). We include within this review a description of efforts that have been made to address this in the NHS by promoting compassionate leadership. Next, we discuss the existing limited literature and theory on compassionate leadership. In this context, we also consider the more developed research literature on organizational compassion, whence theorizing about compassionate leadership tends to draw. Acknowledging that current research on compassionate leadership is limited, we explore some implications and research questions that emerge from viewing compassionate leadership through theoretical lens of power, paradox and conservation of resources. We conclude with final reflections

on the importance and significance of further researching and cultivating compassionate leadership in healthcare.

The Need for Compassionate Leadership in Healthcare

The need for cultivating compassionate leadership in the NHS is reflected in the consistent overrepresentation of bullying and harassment over many decades (Simpson and Simpson, 2021), with the latest findings reporting that in 2020 12.4 per cent of NHS staff reported having been bullied by managers and 18.7 per cent reported bullying by colleagues (NHS, 2021). These findings are not isolated. Outside of the UK research has found that, relative to other occupations, bullying and workplace harassment tends to be more prominent among healthcare workers (European Agency for Health and Safety at Work [EU-OSHA], 2009; Atkinson and Jones, 2018). A survey of 762 registered nurses conducted in the Australian healthcare context suggested that 61 per cent of respondents had experienced at least two bullying instances in the prior 12-month period (Allen et al., 2015). While nurses appear to bear the brunt of bullying behaviours in healthcare, they are by no means the only victims. In a study involving 747 Australian doctors, 25 per cent reported experiencing some form of bullying within the 12-month period prior to the study (Askew et al., 2012).

These findings are surprising considering that a motivating factor for healthcare workers entering the profession is the virtuous intention of serving humanity with compassion (Eley et al., 2010). The need for upholding strict standards is sometimes given as an excuse for bullying in the healthcare context. Where lives are at stakes there is no margin for error. Interestingly, counter to this justification, research suggests that a key variable in enhanced patient outcomes is carers feeling psychologically safe, with psychology safety defined as "a shared belief that the team is safe for interpersonal risk taking", or "a team climate characterized by interpersonal trust and mutual respect in which people are comfortable being themselves" (Edmondson, 1999: 354). For Worline and Dutton (2017) the psychological safety research suggests the importance of a workplace culture of compassion in contributing to superior performance.

Returning to the NHS context, a series of reports commissioned in the 2000s, including the Francis Report (2013), the Keogh Review (2013), and the Berwick Review (2013), sought to identify the underlying cause of the endurance of poor relational issues in the NHS. These studies (and others like them) have underscored systemic issues of resource constraints, a leadership focused on meeting quantitative targets and balancing budgets over listening to staff concerning their needs in doing their jobs, and a toxic blame culture among managers and staff as underlying causes of constrained

employee voice, low trust and overall poor work relations (Hendy and Tucker, 2020; Tucker et al., 2021). These factors were also seen as contributing to high levels of employee absenteeism, sick-leave, compensation claims and turnover, all of which are known to erode staff morale, wellbeing and the quality of patient care (Kline and Lewis, 2019). In other words, bullying and compassion are not just considerations of individual character, they are also informed by organizational practices of leadership, culture, values, routines and resourcing (Simpson et al., 2020).

Efforts to improve work experiences in the NHS over recent years have included the development of internal mediation services, cultivating a learning culture, and working with staff and unions to quickly resolve tensions, as well as highlighting the need for more compassion, including compassionate leadership, in interpersonal dealings. Regarding the latter, in 2012 Jane Cummings, Chief Nursing Officer for England NHS Commissioning Board and Director of Nursing Department of Health, along with Viv Bennett, Lead Nurse, Public Health England, responded to these findings by launching "Compassion in practice" as a three-year vision (Cummings and Bennett, 2012). Their report, based on engagement with 9,000 nurses, midwives, care staff and patients identified "Action Area 4: Building and strengthening leadership" as one of six action areas critical for cultivating an organization wide culture of compassion. A follow up 2014 report "Building and strengthening leadership: Leading with compassion", also by the Chief Nursing Officer for England NHS (Cummings, 2014), sought input from influential nurse leaders from across England to "identify key areas that we needed to progress in relation to leadership" (p. 3). The report recognised the development of leadership that supports a culture of compassion in healthcare as a complex "wicked problem" (p. 10), one that cannot be solved with a single "attribute, force or mechanism". It recommended that interventions for cultivating compassion ought to target four levels: "i) the self; ii) the manager/leader; iii) the team; and iv) the organisation, and usually must be targeted at all four for compassion to truly thrive" (p. 7). A "Developing People – Improving Care Framework" was subsequently launched by The National Improvement and Leadership Development Board (2016), which has representation from thirteen healthcare related organisations including the Department of Health, Public Health England, NHS England, NHS Health Education England, NHS Leadership Academy, NHS Improvement, National Institute for Healthcare Improvement (NICE), Local Government Association and the Care Quality Commission. One of four critical capabilities the framework focused on was developing: "inclusive and compassionate leadership, so that all staff are listened to, understood and supported, and that leaders at every level of the health system truly reflect the talents and diversity of people working in the system and the communities they serve". The relational tensions surfaced in the NHS by COVID-19 despite the release of various strategy documents and frameworks for developing compassionate leadership of the years, reinforces that

enacting culture change is not easy in practice. It also begs the question, what is compassionate leadership?

What is compassionate leadership?

Understanding of compassionate leadership builds on the theorising and findings of the broader discipline of *organizational* compassion research over the past couple of decades (for a review see Dutton et al., 2014). Organizational compassion scholars discuss compassion as something that arises within a context of suffering (Kanov, 2021). Intrinsic to the human condition, suffering can manifest from any number of causes including personal circumstances of grief on the death of a loved one or a relationship break up; personal loss or injury from natural or human made disasters or workplace accidents; or emotional pain experienced from relational conflict, including in the workplace. Compassionately addressing workplace suffering, through efforts in which leadership frequently plays a significant coordinating and sanctioning role (Dutton et al. 2002, 2006; Simpson, Cunha and Clegg 2015), is generative of significant positive physical, emotional, relational and professional-performance effects (Figure 2). Among these are the hastening of post-trauma healing (Dutton et al., 2002; Powley and Cameron, 2006); enhancing connection, altruism, motivation, pride and loyalty (Dutton et al., 2007; Lilius et al., 2008; Simpson, Cunha and Rego, 2015); promoting perceptions of leadership effectiveness and superior decision making (Boyatzis et al., 2006; Cameron et al., 2011); and boosting organizational performance levels (Cameron et al., 2004). Within the healthcare context research has found that individual experiences of compassion are associated with higher levels of affective staff commitment and positive emotion (Lilius et al., 2008), improved sleep quality and subjective health, reduced work-related stress and reduced workplace bullying (Zhang et al., 2018). Organizational compassion research has identified that compassion from a leader, signals that those with the power to provide resources that might facilitate coping and recovery, are attentive to situations of distress (Dutton et al., 2006).

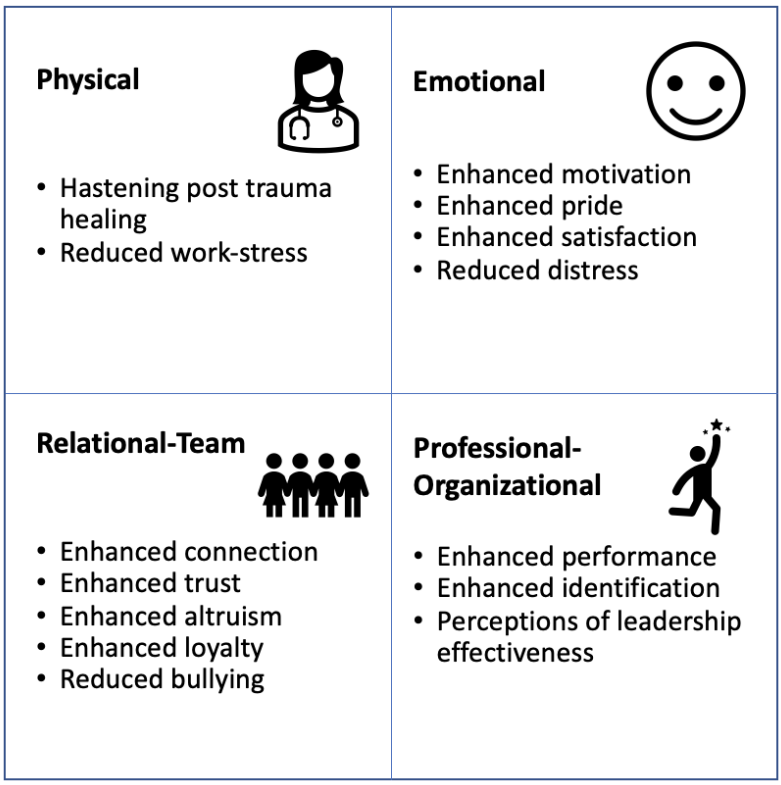

Figure 2: Some effects of workplace compassion and by inference compassionate leadership.

Compassionate leadership as a NEAR process

Organizational scholars approach compassion not merely as an emotion or even as a virtue but rather as a collective process that comprises four NEAR subprocesses: *noticing* the suffering of a colleague, *empathising* with their pain, *appraising* their circumstances to understand their situation better, and *responding* in the most appropriate manner to alleviate their suffering (Simpson et al., 2020). Drawing on this definition, compassionate leadership has accordingly been defined as a process wherein a leader enacts these NEAR practices to address their follower's suffering (Figure 1) (West, 2021).

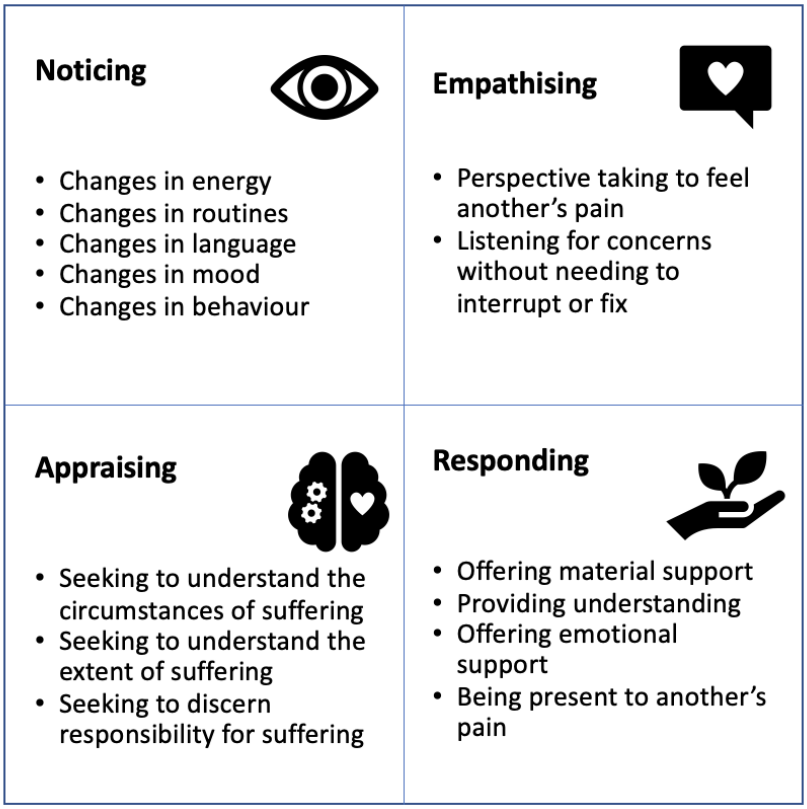

Figure 1: Compassionate leadership can be defined as leader engaging in NEAR behaviours to address the suffering of their followers.

Noticing

In noticing, a leader (manager, supervisor) pays attention to signals of suffering amongst those under their charge (Simpson, Cunha & Clegg 2015). Suffering may also be signalled through an explicit call for help, but more often the signals are implicit, indicated through changes in mood, energy, routines, language or behaviour (Dutton, Workman & Hardin, 2014). Outbursts, mistakes and missed deadlines can be blamed on the individual and further compound feelings of inadequacy, burnout and turnover. They can also be taken as implicit cries for help. A respondent cited in a research project on the effects of efforts to develop compassionate leadership capabilities in the NHS observed that emotional intelligence is important for noticing the suffering of their rapports: "Emotional intelligence is vital, and the ability to sense verbal and non-verbal patterns of behaviour – to see when people are with you, and when they are not, or when they have concerns" (Cummings, 2014, p. 24).

Empathising

A leader empathises with their followers by feeling their struggles, identifying with their followers' sufferings as their own. Figuratively, empathy entails the ability to imaginatively place oneself in the follower's 'shoes' or 'skin' through perspective taking (Dutton, Workman & Hardin, 2014). Capabilities of self-compassion, mindfulness – or moment to moment awareness of feelings or events

without passing judgement, as well as active and reflective listening skills can support a leader in empathising with the suffering of those they lead (West, 2019). Empathy can be built into organizational routines through regular team check-ins, as one NHS leader explained: "I run a 'communication cell' each week. It reduces the opportunity for things to get out of control: 'What's gone well or was difficult that you need time from the group on?', 'What are your challenges coming up?'. There are some operational bits but the majority is task-related mutual support" (Cummings, 2014, p. 47).

Appraising

Leaders appraise the struggles of those under their charge through an active curiosity about the specific circumstances and causes of difficult work situations that underlay staff suffering (West, 2019). The practical end of effective appraising by a leader is an understanding of the follower's needs and a sense of what can be done to address their distress. Vital to such a process is active listening. Behind individual outbursts of anger, on the job mistakes and missed deadlines, there may be personal struggles with systemic issues of under resourcing, over work, unrealistic time pressures, and even experiences of harassment and bullying (Simpson, Clegg and Pitsis, 2014b). West (2019, p. 330) suggests that compassionate leaders initiate their appraisals with a "default positive assumption that others are good, capable and worthy of compassion – offering the benefit of the doubt". Even where the leader's appraisal concludes that their report is personally responsible West observes that: "Leaders can withhold blame by steering conversations toward learning".

Responding

Leader's respond to the suffering of their followers by acting (Dutton et al. 2006). When leaders act, it sets the tone for expected behaviour within the organisation, translating precept into example that can be emulated by others (Simpson, Cunha and Clegg, 2015). A respondent to an NHS study offered this view on the importance of compassionate action by leaders: "Compassionate leadership is as needed amongst commissioners and throughout arm's length bodies, assurance and oversight bodies as their actions can either reinforce and encourage collaborative leadership at the front line or significantly undermine it" (Cummings, 2014, p. 42). Leaders taking action often entails improvising to provide material resources, including by increasing staff numbers or the procurement of equipment or technology that lessens workloads and time pressures. At a personal level it might entail approving sick leave, compassionate leave or professional support, or even advance pay. Offering flexible work arrangements is another way that a leader might intervene to address a follower's struggles with work and family responsibilities. Frequently, all that a follower is looking for from their leaders is the

emotional support being listened to and understood. A leader can provide emotional support by their presence, standing with followers during their times of individual and struggle.

A Systems View of Compassionate Leadership

Generalising existing organizational compassion research and the NEAR definition to the leadership context is a helpful starting point. However, it has its limitations, particularly for larger organizations such as the NHS where the structures may resist a leader or caregiver's compassion capabilities. As such compassionate leadership must be conceived from a systems view, where compassion is integrated systemically within organizational processes (Simpson, 2021): "The 'organisation' establishes the infrastructure, the systems and mechanisms to support (or thwart) managers to enact desired values and behaviours, such as compassion, as they in turn support and guide teams and individuals" (Cummings, 2014). Of vital importance here are mechanisms of organizational culture, routines (including hiring, promotion, training and development), social structures as well as organizational discourse and communication (Dutton et al. 2006; Simpson et al. 2019). In a chicken and egg situation, compassionate leadership is important for championing, initiating, and facilitating such system wide integration.

Despite the growing literature on *organizational compassion* and an abundance of leadership theorizing and models, there still is little academic research on *compassionate leadership,* including within the NHS (Simpson, 2021). Aside from work generalising existing organizational compassion research and the NEAR definition to the leadership context, specific components or testable hypotheses of compassionate leadership have not yet been articulated.

A point of departure outside of the healthcare context is a case study of Jacinda Ardern (Simpson et al., 2022), a world leader who "proudly" self-describes as "an empathetic, compassionate leader" (Ardern, 2018) and who has been recognised as such by other leadership scholars (Panayiotou, 2020; Maak et al., 2021; Johnson and Williams, 2020; McGuire et al., 2020; Wilson, 2020). Analysis of Ardern's leadership through several crises revealed four characteristics of her compassionate leadership that can be generalisable at a broader level (Figure 3): 1) Compassionate leadership is *idealistic,* based on humanistic values that informs a vision of addressing suffering through societal improvement that provides an authentic purpose to leadership as a calling. 2) Simultaneously, it is *pragmatic* in recognising that leadership is performed as the art of possible, requiring a preparedness to negotiate, to be adaptive and to be decisive when opportunity arises or when swift action is called for (as in a crisis). 3) Further, compassionate leadership is *inclusive* in empathizing with and speaking

to the concerns and needs of followers and promoting solutions as a collaborative endeavour co-enacted by the leader and followers. 4) Finally, it is *rational* in that initiatives need to be embedded within policy guidelines and operational systems including those of accountability, and to be informed by science. Individually, each of these four areas has their own logic and might be seen to represent an individual leadership style (authentic, autocratic, democratic or bureaucratic). Combined, they involve tensions between idealism vs. pragmatism and inclusivism vs rationality. Whereas tensions such as these can act as barriers to compassion (West, 2021; Worline and Dutton, 2017), effective compassionate leaders embrace these tensions as paradoxes and navigate them through inspirational rhetoric and effective communication.

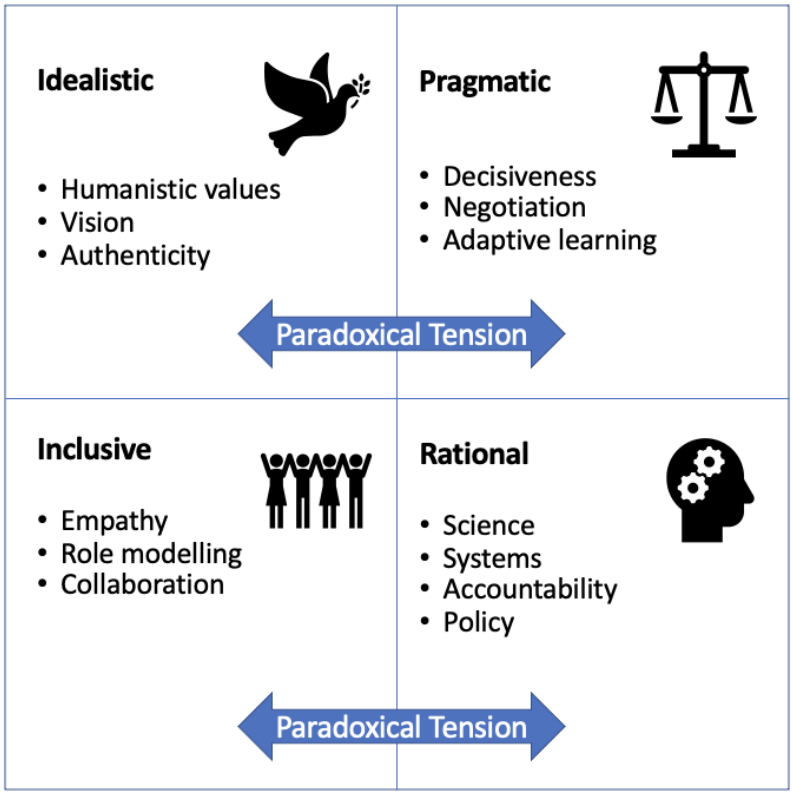

Figure 3: Compassionate leadership, drawing upon and navigating paradoxical tensions between idealism vs pragmatism and inclusivism vs rationality.

In the absence of existing models of compassionate leadership derived from longitudinal studies following the intentional development of compassionate leadership capabilities in healthcare contexts, it can be helpful to explore compassionate leadership by viewing it through various theoretical lens. Such analysis is not only helpful for practice but may also provide insight for developing research programs. To support such an agenda, we next consider three theories: power, paradox and conservation of resources.

Three Lens for viewing compassionate leadership

Viewing a topic through a relevant theoretical lens opens new angles of vision that contribute richness to an inquiry, as stated by Saunders, Lewis and Thornhill (2019: 639): "Qualitative research conducted through the lenses of interpretivist philosophy will affect the nature of the data produced, with implications for their analysis". O'Brien (1993) accordingly compares theoretical lens to a kaleidoscope: "we can see social theory as a sort of kaleidoscope – by shifting theoretical perspective the world under investigation also changes shape". The three selected lenses discussed below have all been drawn upon in the academic literature to contribute novel perspectives on organizational and leadership phenomena, including compassionate leadership (Simpson et al., 2021) (Figure 4).

Theoretical Lens	Focus	Applied to Compassionate Leadership
Power 	Power is concerned with an agent's capacity to act in a particular manner, to influence as "power over", to empower as "power to" or co-create communal shared "power with".	Compassionate leaders share power by including staff in decision making and empowering staff to voice their concerns and ideas.
Paradox 	Paradox are made salient by competing but interdependent tensions. They are manifest in healthcare as hybrid identity were two or more identities or roles are fused.	Compassionate leaders effectively navigate tensions between kindness and professionalism in staff relations.
Conservation of Resources 	Conservation of resources posits that suffering arises from threats to resources, actual loss, and a failure to replenish lost resources. Resource caravans are where resource loss/enrichment is followed by further resource loss/enrichment.	Compassionate leaders are attentive to staff/co-worker resource needs (as appropriate) to minimise or address staff suffering.

Figure 4: Viewing compassionate leadership through the lens of power, paradox and conservation of resources offers nuanced insight.

Power

COVID-19 has shifted power relations in working lives, bringing attention to the limitations of leadership imposed as domination "power *over"* someone, where only a single managerial voice is considered as valid (Clegg and Haugaard, 2009). Power theorists suggest that leaders can just as well deploy power as empowerment, where people are given the "power *to*" take initiative in following managerial directives. Most effective, however, is when agents create "power *with"* each other as a co-actants in expressing voice and setting the managerial agenda, as envisaged by Mary Parker Follett (1924), a female management theorist who was ahead of her time. Follett's (1941/2003) circular theory of power espoused replacing bureaucratic institutions with networks of people voicing their views in analysing, producing and taking responsibility for outcomes at each stage of organizational processes. Circular power updates facts in an evolving context, accommodating new interpretations, experiences and insights across time. In leadership, however, the focus has traditionally largely been on *power over* that supresses employee voice, including within the NHS (Pope, 2019; Hendy and Tucker, 2020). Even when voice is encouraged in the NHS, it has often been within limited parameters defined by managerial authority (Hoque et al., 2004; Tailby et al., 2004). The same frequently occurs in organizational compassion relations purported to be grounded in a discourse of *power to* (Simpson et al., 2014a). Follett's ideas suggest that addressing suffering with organized

compassion in the NHS requires co-active *power with,* co-created initially by listening to the voices of NHS employees and partnering with them in agenda setting (Foster, 2016). Research on compassionate leadership in the NHS informed by power theory would ask questions such as: *to what extent are staff being more included in decision making and agenda setting, do they feel empowered to voice their concerns and insights* (Simpson, 2021)?

Paradox

A focus on compassionate leadership as co-active *power with* might suggest a leadership style that is weak, sentimental and ad-hoc (du Gay et al., 2019). In contrast, a paradox lens would acknowledge that compassionate leadership often involves navigating interdependent yet contradictory demands of a hybrid identity in a complementary manner by being simultaneously both professional and kind, strong and empathic (Araújo et al., 2019; Simpson and Berti, 2020). Another example of this is the case of Jacinda Ardern's compassionate leadership discussed in more detail earlier (Simpson et al., 2021). Research suggests managing conflicting hybrid roles is part of what it means to be a healthcare professional (Spyridonidis et al., 2015). What makes this process manageable is when these role expectations are made salient, and the value differing roles is recognised. Applying a paradox lens to compassionate leadership can bring attention to the tensions that compassionate leaders must navigate and may even leverage to harness the power of oppositional forces towards a unified objective. Compassionate healthcare leadership informed by paradox theory would ask: *to what extent are healthcare managers and staff able to navigate sometimes competing demands for professionalism and compassion in interpersonal dealings*?

Conservation of resources

Compassionate leadership is primarily concerned with alleviating suffering (Dutton et al., 2002; Simpson et al., 2021). The primary cause of suffering, according to conservation of resources theory, is a loss of resources, defined as anything perceived by individuals that help them to attain their goals (Halbesleben et al., 2014). Resources are described as "objects, personal characteristics, conditions, or energies that are valued in their own right" (Hobfoll, 2001: 339). Internal human resources include "vigour, hope and self-efficacy" providing "energy and motivation to seek and maintain external resources such as supportive relationships" (Tafvelin et al., 2019: 160). Other relevant resources include internal locus of control (Mallin and Mayo, 2006), supervisor support (Wang et al., 2019; Guan and Frenkel, 2019) supervisory and co-worker support (Cordes and Dougherty, 1993), as well as task complexity, personal decision making and individual autonomy (Spreitzer and Mishra, 2000). These resources can enhance followers' resilience and coping and promote physical, emotional and social wellbeing (Clarke et al., 2015). Conservation of resources further posits resource caravans

where resource loss, or loss enrichment, follows further loss or enrichment. Theorising compassionate leadership in healthcare as a process of mitigating suffering by conserving, developing and replenishing staff and patient resources is a helpful way of operationalising the practice and objectives of compassionate leadership. Research on compassionate leadership informed by conservation of resources theory would ask: *to what extent are managers and co-workers attentive to the resource needs of their dependents, colleagues and patients to minimise their suffering*, or *to what extent has addressing resource needs enriched staff and patient wellbeing?*

Discussion

Preliminary research suggests that when healthcare staff are supported by compassionate leaders who provide opportunity for staff to voice their needs and concerns and are attentive to the resources (including emotional, social, relational, physical) staff require to properly perform their roles, staff commitment, engagement and wellbeing will likely improve (Lilius et al., 2008; de Zulueta, 2016). To date, however, we know more about the absence of compassionate leadership than its presence. Less is known about whether compassionate leadership can be learned through staff training and development programs. If compassionate leadership training is found to deliver significant improvements in developing healthcare managers "'softer' people skills" (Soundry, 2020: 2-3) by equipping them to "identify, address and resolve challenging people issues", this outcome would constitute a significant research contribution and source of great hope. It would also contribute towards realising the determinations and recommendations of the Francis Report (2013), the Keogh Review (2013), and the Berwick Review (2013), as well as various internal NHS studies, strategies and policy frameworks for developing compassionate leadership (Cummings and Bennett, 2012; Cummings, 2014; National Improvement and Leadership Development Board, 2016). In the meantime, generalising existing *organizational* compassion research to the compassionate leadership in healthcare context is a good starting point. Theorising about compassionate leadership by viewing it through the lens of well-established organizational theories such as power, paradox and conservation of resources can also be helpful.

Conclusions

In this chapter we have sought to broaden understanding of compassionate leadership in healthcare, using the UK's NHS and the COVID-19 pandemic as a context for our discussion. We structured the chapter by initially providing a background of the poor workplace relationships often found in the UK NHS (and healthcare more broadly even outside of the UK) where workplace bullying and harassment tends to be over-represented as compared to other sectors and the workforce more

broadly. Several NHS reviews commissioned in the 2000s found that even if carers enter the profession with a compassionate intention to help others, if they are not supported by a leadership that values care over efficiency and productivity, it can precipitate a work culture of scarcity and blame and limit the resource of care and kindness that carers have for each other, with patients ending up paying the highest price with poorer health outcomes. This description was followed by a review of various NHS policy and planning initiatives to address this highlighting the need for compassionate leadership in healthcare. We then considered the limited existing research and theorising on compassionate leadership. What does exist at a more developed level is a research literature on organizational compassion describing the positive effects and contingencies of compassion in the workplace, including the finding that leadership plays an important role in promoting and roll modelling workplace compassion. It is from this literature that compassionate leadership tends to be conceived of as a NEAR process aimed at addressing the suffering of their rapports. Acknowledging limitations to the current body of research on compassionate leadership we explored some novel insights and relevant questions that emerge from viewing compassionate leadership through various theoretical lens. We conclude by reinforcing that in healthcare, it is important to provide an organizational environment where leaders are seen to role-model compassion and to integrate compassion within organizational policy and practice alongside any efficiency and performance agendas. Compassion like charity begins at home, unless carers are supported with compassion, it undermines the compassionate care they can provide to their patients.

Into Practice

1. Healthcare leaders and managers view addressing staff suffering as part of their responsibility
2. Leaders can be trained in developing compassion capabilities related to the NEAR subprocesses
3. A systems view of compassionate leadership must also be maintained, where leaders integrate compassion within organizational culture, routines, social architecture and communication
4. Resources are required for funding research on the practice, effects and development of compassionate leadership in healthcare

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