Collective Compassion: How Structures and Agency Influence Individual, Group, and Organizational Compassion in Healthcare Organizations

by

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ABSTRACT

This dissertation examines compassion in healthcare organizations through a lens of structuration theory. The purpose of this study is to identify structures that healthcare workers describe as enabling and/or constraining compassion, and the ways that healthcare workers (re)produce and transform these structures. Through qualitative, semi-structured interviews with healthcare workers, this study reveals that multiple structures in healthcare constrain compassion at different stages of the compassion process (i.e., recognizing, relating, and (re)acting). Findings also illuminate how healthcare workers engage in individual and collective compassion to support coworkers, which can (re)produce or challenge the status quo of compassion in organizations. This study extends compassion scholarship by: (a) delineating the differences between individual compassion, group compassion, and organizational compassion, (b) highlighting how structurational divergence in healthcare stunts compassion, (c) examining the limits and consequences of emphasizing compassion in healthcare, and (d) offering insight on the varied success of compassion programs.
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CHAPTER 1
INTRODUCTION

“I think that if my organization had more compassion at different levels—from higher up to the bottom down—then there would be a lot less turnover, and there would be a lot less burnout… If the entire environment was more compassionate and if there were more instances of compassion, then I would definitely consider staying for longer.” (Brooke, 24, pharmacy technician)

Compassion is essential in times of suffering. As a “generative force” (Dutton & Workman, 2011, p. 402), compassion has the potential to transform organizations into sites of healing, comfort, and human connection. Often organizational stakeholders fear compassion in the workplace, viewing it as a threat to reason, professionalism, and justice (Batson et al., 1995). However, perceptions of compassion at work have been linked to emotional commitment to the organization (Lown et al., 2020) and feelings of job satisfaction and accomplishment (Simpson & Farr-Wharton, 2017). Compassion can also generate relational resources such as trust, connection, and positive emotions among coworkers (Dutton et al., 2007). Most importantly, “compassion heals” (Dutton et al., 2002, p. 54) in response to the pain and suffering that inevitably appears in organizational life (Frost, 1999).

Therefore, compassion is arguably necessary in any type of organization (Kanov et al., 2004). Given that stress and burnout are especially pervasive in healthcare (Carayon et al., 2019), the benefits of compassion could be exponential in these contexts. Research shows that physicians are twice as likely to suffer from burnout compared to those in other professions (Krisberg, 2017), and burnout rates among all types of
healthcare workers are reaching new heights during the global COVID-19 pandemic (Morgantini et al., 2020). Left unaddressed, burnout yields a variety of consequences for both individuals and organizations in healthcare, such as: negative health outcomes for employees (Maslach et al., 2001), poor physician-patient rapport (Ratanawongsa et al., 2008), and ineffective communication with patients (Passalacqua & Segrin, 2012).

However, when healthcare workers demonstrate empathic concern toward each other, their burnout is likely to be reduced (Gerber & Anaki, 2021). Conversely, perceptions of low compassion in the workplace have been linked with higher turnover rates in healthcare (Lown et al., 2020). As such, compassion should be regarded not only as a generative force for positive outcomes (Dutton & Workman, 2011), but also a protective mechanism that could ameliorate stress and suffering among healthcare workers.

To date, the construct of compassion has largely been explored from a management perspective—treated as an individual phenomenon unfolding within the workplace. Although some management scholars have explored the conditions in which compassion is more likely to spread among organizational members (e.g., Dutton et al., 2006; Kanov et al., 2004), the communicative construction of compassion is still relatively underdeveloped. More recently, communication scholars (e.g., Huffman, 2017; Miller, 2007; Tietsort, 2021; Way & Tracy, 2012) have advanced theorizing of compassion as inherently interactional. When compassion is regarded as a form of interpersonal work, it becomes easier to recognize the communication competence and skill necessary for compassion to occur (Frost et al., 2006). However, interactions are not removed from the contexts in which they occur. Moreover, scholars have yet to fully
consider how compassion moves from dyadic and interactional into collective and organizational through communication process.

Compassion has been described as “an innate human instinct to respond to the suffering of others” (Dutton et al., 2006, p. 60), but research has also shown that compassion does not unfold readily in all organizations (Kanov et al., 2017). In some organizations, employees may be uncertain of the (in)appropriateness and legitimacy of displaying compassion in the workplace (Kanov et al., 2017). This emotional display uncertainty is present in healthcare organizations, where compassion among employees is rarely discussed or rewarded (McClelland & Vogus, 2014). In fact, emotional displays of any kind are limited because many healthcare organizations operate under systems that emphasize capitalist outcomes over the development of meaningful relationships (Bisel & Zanin, 2016; Dutta, 2008). Such systems ignore healthcare worker potential for providing social support, practical information, and empathic communication among coworkers—all of which are powerful buffers against stress and burnout (Segrin & Passalacqua, 2010). Research suggests that healthcare organizations would benefit from cultivating compassion in organizational life—a process that would simultaneously sensitize workers to both the emotional sources of pain in healthcare work (Madden et al., 2012) and the pathways for responding effectively through empathy and action (Dutton et al., 2006).

To transform an organization into a site of healing, comfort, and human connection, compassion must permeate every facet of organizational life (Dutton & Workman, 2011). Research has shown that employees can promote this effort by individually engaging in the compassion process and exercising related skill sets in cognition, emotion, and communication (Kanov et al., 2004; Miller, 2007; Way & Tracy,
However, compassion should not be regarded solely as an individual responsibility. Individual acts of compassion may provide some degree of relief against the stress that seemingly characterizes healthcare work, but individual acts alone will not radically alter how an organization recognizes and responds to stress and suffering. Similarly, organizational compassion should not be reduced to hiring a group of compassionate employees (Kanov et al., 2004). Compassion can also be cultivated—or inhibited—through members’ (re)production of organizational structures. In other words, the pursuit of compassion at the organizational level requires rules and resources that foster the collective capacity to engage in compassion. An examination of the (re)production of structures in healthcare organizations may illuminate how compassion can be communicatively constructed and felt at multiple levels within an organization.

Some scholars argue that all organizations have the capacity to foster compassion and virtuousness (Cameron et al., 2003). Given this perspective, the purpose of this study is to examine how compassion is enabled and/or constrained in healthcare organizations. This study is framed by compassion scholarship (e.g., Frost et al., 2006; Kanov et al., 2004; Way & Tracy, 2012) and structuration theory (Giddens, 1984) to explore the overarching structures that enable and/or constrain the compassion process, and the ways that healthcare workers (re)produce and transform these structures. Investigating compassion through a lens of structuration theory provides an opportunity to extend theorizing on compassion, moving it from individual and interactional work to an organizational capacity. The following sections (a) provide an overview of compassion scholarship, (b) explain the major constructs of structuration theory, (c) contextualize
suffering and compassion in healthcare organizations, and (d) discuss programs of organizational compassion as seen in previous research.

**Literature Review**

The study of compassion and its related attributes (e.g., sympathy, empathy, generosity) dates back centuries to the philosophies of Aristotle, who is arguably the earliest known advocate of an ethics of care (Curzer, 2007). Despite its early inception, compassion remains somewhat an elusive concept in the realm of empirical and theoretically driven research, leading some scholars to claim that “the term ‘compassion’ has been much used and little discussed” (Saunders, 2015, p. 121). Indeed, compassion appears to be a simple concept, and there is an assumption that everyone already knows the meaning and nature of compassion (Saunders, 2015). However, the concept of compassion has evolved considerably over the years, encouraging scholars to reevaluate the features and functions of compassion. This section outlines varying conceptualizations of compassion at the individual and organizational levels.

**An Overview of Compassion Scholarship: Individual Versus Organizational Compassion**

**Individual Compassion**

In fields such as psychology and neuroscience, compassion is portrayed as an innate trait—the tendency to have empathy, sympathy, and concern for others (e.g., Hou et al., 2017). A trait view of compassion suggests that some people are biologically inclined to be compassionate while others are not. Psychologists have argued that individual differences affect displays of compassion, including personality traits (e.g., extroversion, agreeableness), abilities (e.g., psychological flexibility), and demographic
characteristics (e.g., gender, socioeconomic status) (Dutton et al., 2014). Other scholars have described compassion as a basic emotional state triggered by seeing someone in suffering (Nussbaum, 1996). Although these perspectives of compassion have interesting implications and may even resonate to some extent, they leave little room to view compassion as a developable skill set. Contemporary compassion scholars largely agree that compassion is a three-step process with practicable skills (Dutton et al., 2014; Kanov et al., 2004; Miller, 2007; Way & Tracy, 2012).

Kanov and colleagues (2004) were among the first scholars to significantly engage with Frost’s (1999) call for organizational research focused on compassion. To move compassion away from abstraction and toward a concrete occurrence in organizational life, these scholars described compassion as a three-step process involving: (a) noticing an individual’s suffering, (b) feeling their emotional pain, and (c) responding with an action that could alleviate their suffering (Kanov et al., 2004).

Communication scholars later expanded upon this model by offering nuance to the steps of the compassion process. For example, Miller (2007)’s view of compassion as emotional work is particularly notable for reconceptualizing feeling (as a psychological process) into connecting (as a relational process). Miller (2007) asserted that connecting requires both cognitive and affective skills in perspective-taking and empathy, respectively.

Building on these works, Way and Tracy’s (2012) model reimagined the familiar steps of the compassion process as: (a) recognizing, (b) relating, and (c) (re)acting (Way & Tracy, 2012). Importantly, this model infuses communication in every subprocess of compassion. Whereas noticing was primarily considered a cognitive skill in previous
models, recognizing requires “understanding and applying meaning to others’ verbal and nonverbal communicative cues, the timing and context of these cues as well as, cracks between or absences of messages” (Way & Tracy, 2012, p. 307). Recognizing involves attention and interpretation of the meanings of spoken and unspoken pain. Echoing and extending Miller’s (2007) concept of connecting, Way and Tracy (2012) describe relating as “identifying with, feeling for, and communicatively connecting with another to enable sharing of emotions, values, and decisions” (p. 307). Relating uniquely emphasizes the importance of communicative interaction in building deeper connections and establishing common ground between two parties. Finally, (re)acting is defined as “engaging in behaviors or communicating in ways that are seen, or could be seen, as compassionate by the provider, the recipient and/ or another individual (Way & Tracy, 2012, p. 307).

Contrasting from early conceptualizations where responding was not possible without first engaging in noticing and feeling (Kanov et al., 2004), Way and Tracy (2012) argue that compassionate actions can precede feelings of empathy. Additionally, (re)acting allows for the possibility of proactive compassion, even before suffering has been recognized. Altogether, Way and Tracy’s (2012) model embraces the dynamic and nonlinear nature of compassion. The evolution of compassion conceptualizations can be seen in Table 1, as reproduced from Way and Tracy (2012).

Table 1

Evolution of compassion conceptualizations, reproduced from Way & Tracy (2012, p. 307)
In more recent years, scholars have suggested the inclusion of additional steps in the compassion process, such as appraising (Atkins & Parker, 2012), assessing (Simpson & Farr-Wharton, 2017), or sensemaking (Dutton et al., 2014) to address potential tensions or theoretical gaps in original three-step process of noticing, feeling, and responding (Kanov et al., 2004). These revisions to the compassion process focus on how people may engage in additional evaluations of the sufferer’s situation, whether their suffering is deserved, and how new interpretations may affect the nature and scope of a compassionate response (Atkins & Parker, 2012; Dutton et al., 2014; Simpson & Farr-Wharton, 2017). While these additions have merit, Way and Tracy’s (2012) model effectively subsumes such steps by conceptualizing compassion as a process where one can double-back and revisit each subprocess of compassion. When compassion is positioned as an inherently communicative process, it is easier to see how interpretations...
and feelings can dynamically change in light of new information and communicative interactions.

The evolution of the compassion process has suggested that while the desire to be compassionate towards others may be innate (Dutton et al., 2006), the execution of compassion is considerably complex. Compassion requires an individual to be intentional and practiced in skills such as identification, perspective-taking, and empathy (Way & Tracy, 2012). Additionally, compassion requires communication skills such as “listening, attending to nonverbal cues, and providing verbal social support” (Way & Tracy, 2012, p. 293). It is also important to recognize that these skill sets appear in a relational context where meaning is affected by conversation partners’ similarity, closeness, and social power (Dutton et al., 2014). Changing contexts and relational partners elevate the need for expertise in these skill sets. A compassionate act may not be interpreted as appropriate and effective in all situations (Canary & Spitzberg, 1987), so individuals would need to continually monitor the nature of the situation and relationship and adjust accordingly. Responding compassionately to others requires communication competence in verbal and nonverbal strategies, including balancing informational and emotional content in messages and displaying immediacy behaviors (Miller, 2007). Research has also shown that people can intentionally embody compassionate communication by being present, immediate, and serving towards others (Huffman, 2017).

The latest conceptualizations of compassion as a process and skill set emphasize that all humans have the ability to increase their competency in compassion. However, when compassion is purely defined as an individual process and skill set, there is also an underlying implication that compassion might be considered an individual responsibility.
Given the complexity of compassion as a skill set—requiring affective, cognitive, and communicative competence—individuals must adapt to unique relationships and situations. It is likely that the activation and execution of the compassion process requires considerable effort from the individual. Although the desire to help others is arguably instinctual (Dutton et al., 2006), desire alone does not guarantee there will be sufficient energy to enact compassion and the skill to do so effectively. Managers may expect employees to act compassionately toward one another, even when organizational structures have not created incentive or set a precedent for compassionate behaviors. Additionally, for employees who are experiencing burnout and thus have diminished energy and motivation (Demerouti et al., 2001), exercising compassion towards others may seem particularly strenuous and unachievable.

When compassion is implied to be an individual responsibility, it is easier for organizational stakeholders to dismiss compassion as an extra-role behavior—a boon to the workplace but not a necessary element. Treating compassion as expendable may be especially prevalent in healthcare organizations, where emotional training is usually absent or overlooked in favor of other skills that clearly relate to in-role job expectations (e.g., technical skills, medical acumen) (Hafferty, 1988). An inattention to compassion and emotion in healthcare organizations is paradoxical, given that healthcare work is indeed emotional. In addition to managing feelings that result from dealing with illness and/or death on a daily basis (Aase et al., 2008), most healthcare workers grapple with tacit expectations to engage in empathic communication with patients (Hardee & Platt, 2010; Sorenson et al., 2016). Without proper training and resources, healthcare workers may be inclined to view compassion as an unnecessary experience and skill set in the
workplace. If compassion is deemed unnecessary in healthcare settings, workers may miss the opportunity to nurture a sense of relatedness and belonging with one another, which is a powerful buffer against burnout (Gerber & Anaki, 2021). However, compassion does not need to be limited to an individual capacity or responsibility. Compassion can also be valuably conceptualized as an organizational capacity and process.

**Organizational Compassion from a Management Perspective**

Compassion has largely been explored from a management perspective. In extant literature, two terms have been used somewhat interchangeably to discuss compassion at the organizational level: organizational compassion and compassion organizing. Kanov and colleagues (2004) defined organizational compassion as “the process in which organizational members collectively notice, feel, and respond to pain within their organization” (p. 821). Kanov et al. (2004) argued that these three subprocesses (i.e., noticing, feeling, and responding) only transform into collective capacities when the processes are legitimated, propagated, and coordinated by organizational members. In other words, compassion is more likely to become a collective accomplishment when employees feel free to display their feelings (i.e., legitimation); when employees can effectively spread ideas, information, and feelings among themselves (i.e., propagation); and when employees can work interdependently to respond others’ pain (i.e., coordination) (Frost et al., 2006). Additionally, past research indicated that these subprocesses can be influenced by an organization’s values, practices, and routines (Kanov et al., 2004). This conceptualization of organizational compassion was innovative for its time because it reframed compassion as an organizational capacity, made possible
through the efforts of employees and tempered by an organization’s unique characteristics. By focusing on the legitimation, propagation, and coordination of compassion, this research suggests that communication should be a central concern in compassion research.

Shortly after the concept of organizational compassion was proposed, Dutton and colleagues (2006) offered an alternative theoretical concept: compassion organizing. Compassion organizing is defined as “as a collective response to a particular incident of human suffering that entails the coordination of individual compassion in a particular organizational context” (Dutton et al., 2006, p. 61). As evidenced by this definition, organizational compassion and compassion organizing share many similarities: both focus on the amplification of the three-step compassion process at the organizational level, and both strongly emphasize the importance of employee action and coordination. Compassion organizing also highlights how an organization’s social architecture (i.e., values, routines, and networks) interacts with employees’ actions to activate attention to someone’s pain and mobilize resources to help (Dutton et al., 2006). This specific work later encouraged other scholars to investigate how other social mechanisms underscore the compassion process, including organizational culture, roles, leadership, and stories told (Simpson et al., 2020), although their terminology switched back to organizational compassion.

Combining these perspectives on compassion, organizational compassion requires the collective and coordinated efforts of organizational members who embody the process of compassion (Dutton et al., 2006; Frost et al., 2006). These efforts are theoretically helped or hindered by an organization’s characteristics or social conditions.
For example, scholars have theorized that organizational compassion manifests when organizations have high levels of agent diversity, role interdependence, and social interactions (Madden et al., 2012). Agent diversity refers to the variation in an organizational body’s makeup. It may be easier to notice, feel, and respond to patterns of pain in the organization when its employees come from diverse backgrounds, offering unique resources and skills in cognition and emotion (Madden et al., 2012). Pain and stress could also be easier to recognize when organizations are highly interdependent because employees in frequent contact may notice unusual behaviors in their peers. Moreover, interdependent employees may be more compelled to act compassionately towards their coworkers because they have likely developed a sense of familiarity and attachment to one another through a history of task coordination (Madden et al., 2012). Such ideas have been theorized but not tested, indicating a warrant for an empirical investigation of organizational characteristics and conditions that may influence the compassion process.

Social interactions are also key in any consideration of organizational compassion. Although quantity of social connections is important (Madden et al., 2012), scholars have especially drawn attention to the quality of social connections among employees (Lilius et al., 2011). High-quality connections are coworker relationships marked by positive regard, mutuality, and flexibility. When employees are attuned to each other’s needs and empathize with each other’s plights, they can create a space for honest conversations about what specific forms of support someone needs and what support others can reasonably provide without engendering burnout (Lilius et al., 2011). Simply put, displays of compassion can be generated and negotiated in conversation. The
communicative construction and negotiation of compassion remains underexplored, but prior research indicates that honest conversations between coworkers are more likely to occur when organizations have dynamic boundary-permeability norms (i.e., an acceptance that some degree of spillover between work and life is normal and human) (Lilius et al., 2011). After all, many stressors and emotions from personal life follow employees into work and vice versa (Miller et al., 2007). Whether a stressor is born at work or brought to work, such pain can be addressed and hopefully alleviated through organizational compassion.

At the individual level, scholars have argued that the success of compassion is not necessarily about eliminating suffering altogether; instead, compassion is often about finding meaningful ways to make pain bearable and survivable (Kanov et al., 2004). Indeed, compassion can even manifest in the form of inaction and providing space to others (Way & Tracy, 2012). These logics still apply to the organizational level of compassion, but the “success” of organizational compassion must also consider the ways in which a collective response to suffering can increase the visibility of the compassion process and set a precedent for future behaviors in the workplace (Frost et al., 2006). As such, scholars (e.g., Dutton et al., 2006; Simpson et al., 2020) have developed criteria for evaluating the efficacy of organizational compassion, including: scale (quantity of resources), scope (variety of resources), speed (amount of time to mobilize and complete actions), and customization (shaping resources to meet particular needs) of responses to suffering. Ideally, organizational compassion creates a pattern over time that indicates when and how organizational resources can be used to alleviate suffering (Dutton et al., 2006).
For the purposes of clarity and building upon Way and Tracy’s (2012) conceptualization of compassion, the current study uses the term *organizational compassion* to refer to an organization’s collective capacity to recognize, relate, and (re)act to suffering in the organization. Importantly, I conceptualize organizational compassion as a collective capacity generated and sustained by communication. Past research has established that organizational compassion is only made possible when employees legitimize, propagate, and coordinate around a shared value of compassion (Kanov et al., 2004). If organizational compassion is achieved through feedback loops and observation of coworkers’ behaviors (Frost et al., 2006), communication is absolutely essential for compassion to occur. In short, organizational compassion is communicatively co-constructed.

**Theoretical Framework: Examining Compassion Through Structuration Theory**

The communicative nature of compassion might conjure an image of compassionate conversation between two people, where compassion is an effortful form of work and application of interpersonal skills (Frost et al., 2006). While compassion is indeed interactional (Way & Tracy, 2012), it is also important to consider the broader context in which interactions occur. Interactions are inherently grounded in structures (e.g., cultures, discourses, institutional power) that provide order and outline systems of conduct in society (McPhee & Poole, 2009). Situated interactions are intimately linked with “social structures of meaning, norms, and power” (Canary, 2017, p. 1688). Likewise, interactions provide space to reflect on structures (McPhee & Poole, 2009). In other words, the communication of compassion is shaped by *and* shapes organizational and societal forces that indicate what it means to recognize, relate, and (re)act to
suffering. Therefore, current understandings of compassion can be extended through a
lens of structuration theory, which would illuminate how organizational compassion is
communicatively constructed in the recursive space between structure and agency. The
following section introduces key constructs of Giddens’ (1984) structuration theory,
which will be used throughout this study to explicate how compassion unfolds in
healthcare.

*Structuration Theory: Major Constructs*

Structuration theory (Giddens, 1984) highlights the inherent complexity of
organizing. Giddens (1984) viewed structuration as a broad social theory, tasked with the
responsibility of identifying the concrete process that comprise social life. As such, the
reach of structuration theory is ambitious and covers the minutiae of both organizations
and society in general. A structuration approach provides a nuanced perspective of
organizational life and is useful for understanding how structures might be considered
simultaneously advantageous and/or disadvantageous in the pursuit of organizational
compassion. For the purposes of the present study, four constructs are particularly
important to understand: structure, agency, the duality of structure, and structurational
divergence.

**Structure.** Structures are “rules and resources, recursively implicated in the
reproduction of social systems” (Giddens, 1984, p. 378). Rules constitute meaning and
sanction modes of social conduct, providing guidelines for how to navigate social
interactions (Giddens, 1984). Rules can be discursive and formalized, just as they can be
tacit and informal. In fact, many rules that guide social interaction are carried in
employees’ practical consciousness, whereby employees tacitly know the expectations of
behavior in daily life without ever articulating them. For example, internal structural rules, shaped by previous communication interactions, have a strong influence on future interactions (Pilny et al., 2017) and reify patterns of behavior among employees (Whitbred et al., 2011). Together, rules and practical consciousness create a sense of routine in organizations.

Resources are also an integral part of structures. Resources are “structured properties of social systems, drawn upon and reproduced by knowledgeable agents in the course of interaction” (Giddens, 1984, p. 15). Resources can be material (i.e., allocative) or nonmaterial (i.e., authoritative). Material resources consist of organizational artifacts, goods, and means of production, whereas nonmaterial resources might include any symbolic or social resource that allows an individual to have influence or command over others (e.g., expert knowledge, reputation, seniority, social connections, etc.). Resources are media for power; like rules, they contribute to employees’ sense of what is routine and normal in organizational life (Giddens, 1984). Regarding organizational compassion, resources are an important means of alleviating employee suffering (Dutton et al., 2006; Simpson et al., 2020).

At the most basic level, structures are the (re)production of rules and resources. All structures in an organization are intertwined, but Giddens (1984) also notes that structures can be separated into three different types: signification, domination, and legitimation. Employees draw upon these types of structures to make sense of an organization and its functions, as well as to determine what action to take (or not take) in any given context. By categorizing structures into different types, scholars can better
understand and complicate how organizational members produce and reproduce the structures of any organization.

Signification structures refer to interpretive schemes, codes, and discourses in communication. For example, healthcare organizations typically favor one of the following signification structures: a discourse of traditionalism serving the interests of physicians, a discourse of liability serving the interests of states and administration, or a discourse of decision-making serving the interests of patients (Olufowote, 2008). Domination structures encompass the power dynamics that affect the mobilization of allocative and authoritative resources. Healthcare organizations rely on both material resources (e.g., monetary support, beds, staff, medications) and nonmaterial resources (e.g., support groups, education) to survive, but the allocation of such resources depend on how power is distributed in the organization (Zanin & Piercy, 2019). Finally, legitimation structures involve the norms and rules that employees draw upon to sanction structures. Legitimation structures in healthcare can range from the Hippocratic oath (Olufowote, 2008) to ideological commitments to “do the right thing” for patients (Carmack, 2017, p. 36) to formal laws and the judicial system (Zanin & Piercy, 2019). Together, structures of signification, domination, and legitimation guide the communication, power, and sanctions in human interaction (McPhee & Poole, 2009).

Structures create a rhythm and routine for organizational life that feel familiar.

Agency. The familiarity of routine is often taken for granted in organizations, understood as simply “the ways things are” or “the way things have always been.” For most, routine is psychologically relaxing, but “in an important sense it is not something anyone can ever be relaxed about” (Giddens, 1990, p. 98, emphasis in original). In
structuration theory, all organizational members are social actors who regularly engage in reflexive monitoring (i.e., keeping track of their actions and the features of the contexts they act in) (Giddens, 1984). This reflexive monitoring creates a potential space where employees may have the opportunity to exercise their agency. Agency is defined as the ability to act otherwise (Giddens, 1984).

An individual’s agency means “being able to intervene in the world, or to refrain from such intervention, with the effect of influencing a specific process or state of affairs” (Giddens, 1984, p. 14). In other words, an individual can act in ways that reinforce or transform existing structures in an organization. In theory, agency means that all employees have the potential to alter or transform the status quo of an organization. However, while all actors have agency, not all actors have access to all the options and resources of structures, particularly those in low authority positions (Zanin, 2018). To act otherwise or challenge the standard routines in an organization, agents must draw upon various structural resources (Giddens, 1984). Presumably, agents try to act in ways that would benefit them, but the outcomes of any action are not guaranteed and may result in unintended consequences (Giddens, 1984; 1987).

In healthcare, agency is seen in the form of creative actions that challenge and/or reinforce structures. For example, physicians often look for workarounds and shortcuts when using new healthcare technologies (Goh et al., 2011). In doing so, physicians both reinforce existing structures by using required technologies (e.g., computerized documentation systems) and challenge structures by looking for innovative ways to use the technologies outside of what is expected. Prior research has also explored how nurses demonstrate agency by taking actions to protect patient safety (e.g., ignoring an
organizational procedure if it may endanger a patient), but such actions are frequently constrained by a lack of resources and inconsistent communication about what the organization values (Groves et al., 2011). Without structural support, the impact of agentic acts may feel muted. In other words, agency allows for the possibility of change in the organization, but agency is also subject to the constraints of structures.

**Duality of Structure.** Looking at structure or agency alone, it may be tempting to characterize one as more influential than the other. This logic reflects a history of dualism between objectivism and subjectivism, or the longstanding debate over whether society (structure) or the individual (agency) should be the primary unit of social analysis (Giddens, 1987). From a perspective of dualism, structure and agency are fundamentally opposed such that structure is external to action. Structuration theory firmly moves away from such dichotomous logic by using the concept known as duality of structure. According to the duality of structure, “structure is both the medium and the outcome of the human activities which it recursively organizes” (Giddens, 1986, p. 533). Simply put, actions produce and reproduce structure; simultaneously, structure both enables and constrains actions. The duality of structure frames structure and agency as interdependent and inextricably linked forces.

The duality of structure is “a continuous and indistinguishable cycle vacillating between human action and social structure” (Zanin & Piercy, 2019, p. 185). Employees may even be unaware of the ways that they maintain structure through their social interactions (Giddens, 1984). Due to the psychological comfort of routine, this cycle operates in such a way that current structures are often (re)produced more than they are challenged, but agency comes in many forms and from many people. Again, Giddens
(1984) argues that structures are not external to individuals. Individuals can impact and even redesign the structures of their organizations, which may take time but remains possible.

The fundamental concepts of structuration theory (i.e., structure, agency, and the duality of structure) have been invaluable tools in many studies focused on healthcare contexts. Communication scholars have applied structuration theory to a variety of complex topics such as: healthcare technologies (Barrett & Stephens, 2017), informed consent (Olufowote, 2008), medical error disclosures (Carmack, 2017), injury reporting (Zanin, 2018), and palliative care (Omilion-Hodges & Swords, 2017). One of the most notable applications and extensions of structuration theory is the examination of structurational divergence in healthcare settings, described in more detail below.

**Structurational Divergence.** Structures (re)produced in organizations are not always complementary to one another. To describe this phenomenon, Nicotera and Clinkscales (2010) offer an extension of structuration theory by explicating the concept of structurational divergence (SD) (i.e., a phenomenon where incompatible structures create a nexus, resulting in communication challenges for organizational members). Two main concepts are proposed within the theory: (a) an SD nexus and (b) an SD cycle. An SD nexus occurs when incompatible structures operate simultaneously and appear equally obligatory (Nicotera et al., 2010). For example, nurses often experience an SD nexus in the face of divergent management styles, where one manager might prioritize task accomplishment and the other manager may emphasize relational communication (Nicotera & Clinkscales, 2010). An SD nexus can lead workers to experience a downward spiral of communication known as an SD cycle, which is marked by
unresolved conflict, immobilization, and inability to develop and achieve goals (Nicotera, 2015). The SD cycle may manifest as seemingly “ordinary conflict” among coworkers, but the SD cycle can also manifest as bullying (Nicotera & Mahon, 2013, p. 110). Unsurprisingly, structurational divergence predicts a slew of unfavorable individual and organizational outcomes, including role conflict, burnout, turnover, and depression (Nicotera & Mahon, 2013). In turn, these outcomes predict employees’ job satisfaction and intentions to leave their organization (Nicotera et al., 2015).

Prior research has shown that healthcare organizations are rife with potential for SD, and nurses are especially susceptible to SD cycles given the professional, organizational, and cultural nexuses at which they are positioned (Nicotera, 2015; Nicotera et al., 2010). However, any type of healthcare worker may be caught in an SD cycle, especially those with nonconfrontational conflict styles (Malterud & Nicotera, 2020). SD is an important extension of structuration theory because it carries significant implications regarding agency. Namely, SD results in “agentic impotence” (Nicotera & Mahon, 2013, p. 107); in the face of incompatible structures, healthcare workers struggle to draw upon necessary resources to demonstrate agency. Essentially, SD stunts decision-making. Employees have described SD as “running in concrete” and being caught “between a rock and a hard place” (Nicotera & Mahon, 2013, p. 108). Even if action is taken within an SD cycle, it will likely only address one structure while neglecting the other. Given that agency is partially constricted in SD cycles, it is worthwhile to identify any occurring or potential SD nexuses when examining an organization’s structures.

Structuration Theory and Compassion
Given that organizational compassion is a collective capacity generated and sustained in the communication of social interactions, it is crucial to understand how social interactions are embedded within broader organizational structures. Therefore, structuration theory is a useful lens for examining organizational compassion because it directs attention to the structural factors (the rules and resources) that guide behavior in organizations, as well as the agentic behaviors that (re)produce or transform those same structures. Through this framing, it is possible to investigate how the structures of healthcare organizations may be inhibiting or encouraging displays of compassion at work. Healthcare workers who struggle with embracing compassion in the workplace may be cognizant of the organizational rules (both tacit and discursive) that discourage emotional displays and a lack of resources for creating systems of support among employees. If employees perceive pain and stress as being “private” matters rather than public ones, they may be less likely to form coalitions and speak out against existing structures that limit compassion (Hoffman & Cowan, 2010). Furthermore, if incompatible structures related to compassion are present, healthcare workers may be immobilized in an SD cycle.

When organizations have routines that seem to have little or no room for compassion, employees may find it difficult to recognize opportunities to act otherwise or draw upon structural resources that could foster compassion. Healthcare workers, who operate in organizations with little regard for relationship-building (Dutta, 2008), may feel especially immobilized regarding compassion. However, given rising rates of burnout among all types of healthcare workers (Carayon et al., 2019), the healing and
transformative potential of compassion should not be dismissed. The following section further builds a case for observing compassion in healthcare.

A Case for Observing Compassion in Healthcare

Although suffering and compassion are arguably universal experiences (Frost, 1999), the contexts in which they appear possess interesting implications and may affect how these experiences manifest. Stress and suffering are common feelings in healthcare organizations, and compassion can emerge in response to or in anticipation of such pain. The following sections (a) discuss the nature of suffering in healthcare by drawing attention to common challenges in healthcare work, and (b) describe how compassion may become manifest in healthcare settings.

Suffering in Healthcare

In the context of healthcare, the most likely manifestation of suffering is burnout. Burnout is the general “wearing down” of employees, borne from issues associated with managing work-related stress (Tracy, 2017). Burnout occurs when employees are simultaneously exhausted and disengaged at work (Demerouti et al., 2001), and several aspects of healthcare work are likely involved in the development of burnout.

High Job Demands and Low Job Resources. Members of healthcare organizations face unique challenges that create and exacerbate stress. Healthcare organizations regularly face hospital restructuring, shortages in medical and nursing staff, a lack of professional training opportunities, canceled study leaves, and high turnover rates (McSherry & Pearce, 2018; Ray & Apker, 2010). Some of the most intense job demands in healthcare work include overwhelming workloads, time pressure, and required overtime (McSherry & Pearce, 2018; Ray & Apker, 2010). Healthcare workers
are expected to effectively multitask regardless of workload, which leads to feelings of exhaustion (Huhtala et al., 2021). Prior research shows that even the anticipation of an increased workload can greatly increase emotional strain (DiStaso & Shoss, 2020). Similarly, long hours are associated with declines in empathy among healthcare workers, which in turn leads to lower levels of patient-centered communication (Passalacqua & Segrin, 2012).

The presence of workplace stressors does not always equate to negative outcomes, but employees must feel that they can handle the demands of their job effectively (Janssen et al., 2020). Generally, the intensity of job demands is mitigated by resources such as social support, job control, supervisor feedback, and learning or training opportunities (Maslach et al., 2001). However, job demands in healthcare organizations are not addressed with sufficient job resources. Additionally, the onset of the COVID-19 pandemic has also drawn attention to other insufficient resources in healthcare, such as a lack of personal protective equipment and psychological care for healthcare workers. With intense job demands characterizing healthcare work daily, there is undoubtedly a need for compassion in healthcare organizations, but empirical research has yet to show how job demands relate to the presence or absence of compassion.

**Mixed Messages about Emotions.** Due to dichotomous thinking dating back to Plato, Western societies tend to separate rationality from emotion (Dreyfus, 2006). Many organizations dismiss emotions in the pursuit of reason and rationality (Planalp, 1999), but emotions are a central part of any workplace (Tracy, 2008). Difficult emotions may be brought into the workplace from home, or they may emerge at the workplace as a result of challenging experiences, expectations, and relationships (Miller et al., 2007). In
healthcare organizations, difficult emotions also manifest as a result of emotionally demanding work. Despite this, healthcare organizations generally operate under models that emphasize rationality and minimize emotions (Bisel & Zanin, 2016; Dutta, 2008).

Although physicians receive highly specialized training in the technical aspects of their job, they are often underprepared to meet the emotional demands of healthcare work, both with patients and each other (Hafferty, 1988). Many physicians are drawn to their profession through an altruistic desire to help others (Real et al., 2009), but they are rarely equipped to handle the existential dread and emotional distress that comes with being in an occupation where patient death is a common reality (Aase et al., 2008). Beginning in their student years, many physicians feel a dialectical tension between emotion and clinical objectivity (Harter & Krone, 2001). New healthcare workers are often encouraged to display a detached concern for patients, and messages related to empathy are not clearly articulated in their socialization (Underman & Hirshfield, 2016).

To protect their emotional health, physicians frequently and intentionally choose not to engage in empathic communication with patients to minimize the possibility of emotional fatigue and burnout (Hardee & Platt, 2010). When healthcare workers feel the need to suppress their emotions, they are more likely to experience depersonalization, which is when an individual “responds impersonally and [lacks] sensitivity towards people whom they care for, provide service to, or instruct at work” (Martín-Brufau et al., 2020, p. 4). Depersonalization may manifest in feelings of cynicism and callousness towards others (Glasberg et al., 2007). Depersonalization is especially common in physicians, who often feel that they must “deaden their conscience” and emotions to keep working in healthcare (Glasberg et al., 2007, p. 400).
Although most physicians are socialized to be emotionally distant from patients (Harter & Krone, 2001), healthcare workers are regularly placed into delicate situations where emotion management skills and emotional intelligence are necessary (Carminati, 2021). For example, sharing difficult news with patients is a common occurrence in healthcare settings. Additionally, certain healthcare workers like nurses are more likely to experience the tension between rationality and emotions. Societal expectations portray nurses as naturally compassionate and giving (Apker et al., 2005), and nurses may feel obligated to engage in “comfort talk” communication where they specifically invite emotion-sharing and provide encouragement to patients (Dean et al., 2016). Given conflicting messages about the appropriateness and value of emotions in healthcare work, employees might view compassion as inherently paradoxical in the workplace—a process that requires displays of both weakness and courage (Simpson & Berti, 2020). Over time, competing messages and job demands may result in compassion fatigue, which in turn predict burnout (Hooper et al., 2010).

Compassion in Healthcare

This study examines how the compassion process and its three subprocesses unfold among healthcare workers. Although the construct of co-worker compassion has received limited attention in health communication scholarship, concepts like social support and supportive communication have been explored in depth and may clarify how compassion emerges and can be sustained in healthcare organizations.

First, however, it is crucial to note that social support is not perfectly synonymous with the compassion process (Kanov et al., 2004). Social support encompasses actions that communicate the message that “someone cares about my welfare” (Segrin &
Passalacqua, 2010, p. 313), and it is one of the primary benefits of meaningful workplace relationships. Supportive communication within those relationships provides spaces for healthcare workers to deliver supportive memorable messages in everyday talk, develop coping mechanisms, and manage sources of uncertainty (Ray & Apker, 2010). Social support consists of various actions that people can take to support one another, which coincides with the subprocess of (re)acting to others in suffering. However, the enactment of social support does not necessarily mean that recognizing and relating has occurred. Thus, social support can broadly fall within the compassion process as a means of (re)acting, but it does not fully capture the processual nature of compassion.

In the healthcare industry, social support mostly occurs in the “backstage,” such as in informal conversations (Ellingson, 2003) and meetings (Wittenberg-Lyles et al., 2013) between coworkers. Given that isolation is a predictor of burnout among nurses and physicians (Melnyk, 2020), social support’s potential to build and deepen relationships among healthcare workers is important. Healthcare workers who are satisfied with their levels of social support are less likely to experience stress and burnout (Wright et al., 2010). Social support from coworkers and supervisors are also linked to perceptions of organizational support (Eisenberger et al., 1986; Ogbonnaya et al., 2018). In turn, perceived organizational support has been connected to heightened positive moods (Rhoades & Eisenberger, 2002) and increased mental energy (Jansson von Vultée et al., 2007) in employees.

Notably, perceived organizational support has been shown to increase extra-role performance in employees, including behaviors such as helping and encouraging both new employees and current coworkers (Chen et al., 2009). Altogether, the positive
outcomes associated with social support and perceived organizational support suggest receiving support may give healthcare workers the energy and motivation to look beyond their own circumstances and help others in pain. Perceptions of support may be critical in coordinating action and mobilizing resources for employees in pain, which represents the heart of organizational compassion (Dutton et al., 2006; Kanov et al., 2004). Again, social support may not be synonymous with compassion, but it may indicate where “pockets of compassion” (Kanov et al., 2004, p. 821) exist in healthcare organizations.

**Programs of Organizational Compassion in Healthcare**

Recognizing the rising rates of stress and burnout among healthcare workers, some healthcare stakeholders have attempted to cultivate compassion through formal programs and workplace initiatives. Two notable and recent examples of such efforts are the “Cultivating Compassion Project” for National Health Service staff in England (Curtis et al., 2017) and the “Leading with Compassion Recognition Scheme” in Shropshire and Staffordshire by Health Education England West Midlands (Hewison et al., 2018). These programs were designed in response to calls from the National Health Service in England, whose Constitution strongly emphasizes the importance of compassionate care and compassionate leadership in the healthcare sector. An examination of the strengths and weaknesses of these programs reveals how the pursuit of organizational compassion is complex and elusive, requiring attention to various structures that may foster or inhibit compassion throughout the organization.

The “Cultivating Compassion Project” for National Health Service staff in England was a structural attempt to generate organizational compassion, primarily focused on “compassion awareness training” (Curtis et al., 2017). In other words, the
“Cultivating Compassion Project” attempted to generate organizational compassion through the introduction of new rules and resources in the workplace. This project introduced new rules through a “train the trainers” approach. The “train the trainers” approach essentially encourages cascading learning: the concept is to strategically train team leaders in the fundamentals of compassion awareness and then have those team leaders train their subordinates in monthly meetings. As the training and information spread throughout the organization, the hope was to introduce a new discourse that compassion awareness (i.e., noticing; see Way & Tracy, 2012) was both expected and valued in the workplace. This program also introduced new resources to the workplace through the creation and distribution of an online toolkit featuring a variety of “compassion resources” such as group activities on mindfulness, links to published literature, and digital stories from employees. Links to published research and digital stories (e.g., employee testimonials and examples of acts of compassion) are examples of allocative resources. Guided by the principles of appreciative inquiry, digital stories were included to “focus on the prevalence of compassion in practice rather than its absence, as a positive means of generating discussion, recognising and appreciating participants’ own positive experiences, and encouraging individuals to undertake a role in promoting ‘compassion awareness’ in their practice” (Curtis et al., 2017, p. 156). In sum, the “Cultivating Compassion Project” focused on highlighting existing practices of compassion worthy of continuation in the healthcare organization.

Similar to the “Cultivating Compassion Project,” the “Leading with Compassion Recognition Scheme” by Health Education England West Midlands (Hewison et al., 2018) also focused on the importance of compassion awareness termed “compassion
recognition” (i.e., noticing; see Way & Tracy, 2012). A unique feature of this program was an emphasis on rewarding compassion through a formal structure in the organization. Healthcare staff were invited to nominate anyone who led with compassion, regardless of occupational position or title, via a written or website submission. Then, nominees would receive a badge in recognition for acting compassionately, as well as a card outlining the reasons for the nomination. There were no caps on the number of nominations that could be processed in the organization. This program could also be considered a structural attempt to generate organizational compassion. The motivation driving this project was not necessarily rewarding individual acts of compassion, but instead “raising the profile of compassion, and also [creating] a ‘feel good factor’ on the part of the nominees and nominators” (Hewison et al., 2018, p. 343).

These programs clearly illustrate the importance of generating employee awareness on compassion. Both programs documented positive and worthwhile outcomes. For example, employees praised the “Cultivating Compassion Project” for encouraging self-reflections and opening spaces for group dialogue on compassion (Curtis et al., 2017). Similarly, employees under the “Leading with Compassion Recognition Scheme” were pleased with their organization’s efforts in fostering mutual support among coworkers (Hewison et al., 2018). Both programs seemingly changed aspects of the workplace environment for the better. However, not all employees welcomed the compassion programs. Many employees expressed skepticism and suspicion about the purpose of the program. In fact, some employees under the “Leading with Compassion Recognition Scheme” wondered if the program was even
counterproductive due to concerns that employees without badges might feel poorly (Hewison et al., 2018).

It is also worth noting that both programs seemed to perform better at the group level but struggled to gain traction across the organization. This lack of traction was often attributed to external factors, such as organizational change (Curtis et al., 2017) and a lack of publicity (Hewison et al., 2018). Although external factors may have contributed to the muted reception of these compassion programs, a closer look through the lens of structuration theory (Giddens, 1984) reveals possible weaknesses of these programs.

First, both programs may have overestimated employee buy-in. As the novelty of a compassion program fades or as organizational leadership espouses other values, organizations must consider how they can reinforce or supplement the rules guiding compassion awareness behaviors. Given that employees are generally more comfortable with routine and status quo (Giddens, 1987), any new rules must be appealing or rewarding enough such that employees are motivated to (re)produce them. Second, the resources provided in these programs may not have met employees’ needs or expectations. If employees were not involved in the design of the program, their needs for certain job resources may not have been targeted through the program. Lastly, both programs were largely focused on compassion awareness/recognition as the key element, but recognizing represents only a fraction of organizational compassion. A program focused only on recognizing may have been viewed as a somewhat incomplete picture of compassion, even if this perception only existed at the level of practical consciousness among employees.
For organizational compassion to be sustainable, compassion needs to be consistently communicated and enacted through organizations’ structures. Compassion should permeate the organization, existing in numerous (if not all) rules and resources that guide employees’ behaviors and interactions. Granted, it is not likely that compassion would consume every aspect of organizational life, but the notion of organizational compassion suggests the existence of various “pockets of compassion” in an organization that usefully guide employee behavior in difficult situations (Kanov et al., 2004, p. 821). Although formal programs of compassion may have positive outcomes, they are generally not holistic enough to reach the level of organizational compassion. Rather than rely on programs alone, organizations should strive to incorporate rules and resources guiding compassionate behavior throughout organizational life.

For example, two hospitals in the southeastern United States have demonstrated a more holistic effort at compassion through a functional model of infusing, sustaining, and replenishing (McClelland & Vogus, 2021). These hospitals “infused” compassion through strategic hiring practices (e.g., behavioral interviewing, organizational fit screening), “sustained” compassion through recognition and rewards (e.g., mission and values monitoring, recognition cards, formal awards), and “replenished” compassion through support for employees suffering from stress (e.g., personal counseling, support forums, financial hardship resources) (McClelland & Vogus, 2021). These compassion practices may not permeate every aspect of organizational life but creating a “bundle” of practices is an important step toward building a compassionate organizational culture (McClelland & Vogus, 2021). Even here, however, there remains an issue of sustainability. Like formal programs of compassion, “bundles” of compassion practices
sometimes struggle to become routinized and legitimated in healthcare organizations (McClelland & Vogus, 2021). This suggests that a compassion-driven structure may be overshadowed by other structures instead.

**The Potential for Organizational Compassion in Healthcare**

Organizational leaders often claim to care about employee wellbeing and compassion yet act in ways that prioritize other values (e.g., the bottom-line, efficiency, discipline, etc.). For many organizations, compassion is merely an obligatory performance, equivalent to “ticking boxes to show compliance with compassionate standards for legal and public relations’ purposes” (Simpson et al., 2014, p. 356). “Compassionate policies” are sometimes used as a mode of power and for plausible deniability (Simpson et al., 2014). Compassion might even be described as a protected resource that managers or those in power can choose to give or withhold from subordinates, which can dramatically affect employees’ organizational experiences (Simpson et al., 2014).

While compassion is a strategic performance in some organizations, other organizations have discourses that outright reject the notion of compassion in the workplace. For healthcare organizations, compassion may not be likely to manifest due to the biomedical discourse, which privileges efficiency, rationality, and authority (Bisel & Zanin, 2016; Dutta, 2008). Healthcare workers may perceive emotions and compassion to be undiscussable in a rational organization. Mixed messages about the appropriateness of emotions in healthcare work often begin during socialization (Harter & Krone, 2001), which may escalate into feelings of depersonalization (Glasberg et al., 2007) or immobilization as healthcare workers are caught between seemingly incompatible
structures (Nicotera, 2015). The perception that compassion does not belong in healthcare organizations is problematic, especially considering the positive benefits that compassion may bring to healthcare workers suffering from stress and burnout (Gerber & Anaki, 2021; Lown et al., 2020). Some healthcare stakeholders have recognized the generative potential of compassion (Dutton & Workman, 2011), resulting in the creation of programs that target organizational compassion (e.g., Curtis et al., 2017; Hewison et al., 2018; McClelland & Vogus, 2021). However, such programs do not necessarily account for how compassion is inherently a communicative process of recognizing, relating, and (re)acting to others in suffering (Way & Tracy, 2012).

At the individual level, compassion can be considered a trait (Hou et al., 2017) or a learned skill set (Kanov et al., 2004). At the dyadic level, where compassion is interactional (Way & Tracy, 2012), compassion is tied to the relational history and context of a relationship (Dutton et al., 2014). At the organizational level, past research suggests that the compassion process is likely related to the structures that guide social interaction (e.g., Madden et al., 2012). Thus, a lens of structuration theory might provide insight into how specific structures in healthcare organizations foster and/or inhibit compassion in the workplace. Especially in healthcare, where organizational life privileges rationality and efficiency (Dutta, 2008), there may be unique structures that influence how employees understand and express compassion to each other. Therefore, the following research question was posed:

RQ1: What structures do healthcare workers describe as enabling and/or constraining compassion in their organization?
Although structures can create deeply engrained routines that guide employee behaviors, structures are not independent of human action (Giddens, 1984). Structuration theory recognizes the potential power of human freewill and choice, which is both enabled and constrained by the structures that employees (re)produce (McPhee & Poole, 2009). Given that organizational compassion is a continual process that must be legitimated, propagated, and coordinated by employees’ actions (Frost et al., 2006; Kanov et al., 2004), it is vital to investigate how healthcare workers draw upon resources to (re)produce or alter rules and routines in healthcare. Scholars have previously argued that organizational compassion is not “the mere aggregation of compassion among individuals” (Kanov et al., 2004, p. 816). It is still unclear how employees co-construct and coordinate compassion through communication processes. These processes are particularly obscured in the context of healthcare where compassion among coworkers is not commonly rewarded or encouraged (McClelland & Vogus, 2014). Additionally, little is known about how healthcare workers utilize their agency for compassion. Thus, the second research question was posed:

RQ2: How do healthcare workers (re)produce or transform structures related to the communication of compassion in healthcare organizations?
CHAPTER 2

METHOD

This qualitative investigation focused on semi-structured interviews to develop an in-depth understanding of healthcare workers’ lived experiences around organizational compassion and burnout. This section outlines information and procedures on the following: the research context, data collection, participant demographics, and data analysis. All procedures were evaluated and approved by an Institutional Review Board at Arizona State University (see Appendix A for IRB approval letter).

Choosing the Research Context and Engaging in Self-Reflexivity

To explore the communicative nature of organizational compassion, four factors were key to consider in the research design of this study: compatibility, suitability, feasibility, and yield (Tracy, 2020). First, compatibility addresses the scholar’s role as a research instrument and encourages self-reflexivity on how the scholar experiences a research context both “despite of and because of who they are” (Tracy, 2020, p. 15, emphasis in original). My experience in healthcare organizations has been from the perspective of a patient or a concerned family member of a patient. During my time in healthcare settings, especially in the context of COVID-19, I have witnessed the overwhelming pressure that healthcare workers face and their desperate need for compassion and support. In one memorable interaction, I recall the way tears filled a nurse practitioner’s eyes as she changed my mother’s IV drip post-surgery. When I gently inquired, the nurse shared that she was at her breaking point—she said she wanted to help others, but she was exhausted and unsure if she was right for the job anymore. This moment and many others left a deep impression on me, igniting a passion to understand
the struggles of healthcare workers and how compassion might mitigate their stress. Although I am not a healthcare professional, my position as an “outsider” provides a unique standpoint and allows me to approach the healthcare scene with curiosity. An “outsider” position can also help me identify aspects of organizational life that “insiders” may not recognize (Tracy, 2020), especially the rules and routines that employees often take for granted in their own organizations (Giddens, 1984).

Beyond my personal compatibility with this research context, healthcare organizations are a suitable choice for projects involving the phenomena of compassion and burnout. A research context is suitable when it provides a stage for theoretical issues related to the research question(s) at hand (Tracy, 2020). Burnout is a historically sedimented issue in the healthcare profession (Krisberg, 2017). Additionally, the onset of COVID-19 has exacerbated the challenges that characterize healthcare work, including intense job demands (e.g., overwhelming workloads, time pressure) and scarce job resources (e.g., limited organizational support, a lack of personal protective and medical equipment) (Carayon et al., 2019). In the context of COVID-19, healthcare workers are now feeling pushed beyond their training more than ever (Morgantini et al., 2020).

Healthcare worker burnout is on the rise in countries across the globe, but this phenomenon is especially prevalent in countries such as the United States where sudden COVID-19 surges have been common (Morgantini et al., 2020). Prior research has also highlighted supportive communication as a common coping mechanism among healthcare workers (Ray & Apker, 2010). Building on this, the current study explores how organizational compassion could be an important vehicle for supportive communication and how it might mitigate burnout in healthcare organizations.
Although COVID-19 increased the timeliness of a study focused on healthcare worker burnout and organizational compassion, a global pandemic also presented unique challenges to data collection. Therefore, I designed this qualitative investigation with careful consideration of feasibility and yield. Feasibility refers to the practicality of the research aims given the research context, and yield is a question of whether the study will deliver the appropriate and desired outcome (Tracy, 2020). As discussed below, I focused on a data collection process that allowed me to recognize the constraints of my participants’ schedules and COVID-related concerns without compromising a synchronous space where their stories and lived experiences could emerge in conversation. The yield of this qualitative investigation enabled me to extend theorizing on organizational compassion and how it unfolds in healthcare organizations.

Data Collection

Participant Criteria and Sampling

All participants fulfilled three inclusion criteria for this study: (a) they were at least 18 years old, (b) they were currently employed by a healthcare organization, and (c) they had worked in their organization for at least one year. In the present study, healthcare workers were defined using the United States Labor Department’s definition: “all employees at physicians’ offices, hospitals, health care centers, clinics, medical schools and other postsecondary institutions offering health care instruction, local health departments, nursing facilities, retirement facilities, home health care providers, laboratories, facilities that offer medical testing, pharmacies, or any similar institution” (Stephenson, 2020, p. 1). In other words, the term “healthcare worker” can apply to a wide variety of occupations (i.e., physicians, nurses, lab technicians, medical assistants,
administrative workers, etc.). Although it was not a formal criterion for participation in this study, all participants also regularly worked in patient-facing positions throughout COVID-19.

Given that healthcare workers are a notoriously difficult population to access, participants were recruited through purposive snowball sampling. Snowball sampling is a productive way to quickly expand a participant pool by asking initial participants to recommend others who also fulfill the study’s inclusion criteria (Tracy, 2020). Participant recruitment mainly occurred over social media (e.g., Facebook, LinkedIn, Instagram) and email (see Appendix B for recruitment materials), and participants were invited to share the call with anyone who fit the inclusion criteria and might be interested. I also encouraged my participants to share my email with anyone who had questions or concerns about participating in the study. Recruitment materials noted that participants who completed a one-hour Zoom interview would receive a $50 Amazon e-gift card for their time.

Although snowball sampling can often result in a more homogenous sample, my final sample of participants could be characterized as a maximum variation sample in regard to healthcare occupations. A maximum variation sample is one where participants represent a wide range of perspectives on the phenomena of interest (Tracy, 2020). The variety of participants in my sample can likely be attributed to two factors. First, the definition for a healthcare worker was broad and allowed for diverse occupations to be represented in the study. Second, many of my participants shared the call for participation on their personal social media and online networking groups, which allowed me to tap into a vast network of healthcare workers across the United States. Overall, the variety of
participants brought a unique complexity and depth to my data (Tracy, 2020), and it was theoretically meaningful to find that various healthcare workers highlighted similar structures that constrain and/or enable compassion in their healthcare organizations.

**Conducting Interviews**

Qualitative data were collected through in-depth, semi-structured interviews using an interview guide (see Appendix C) to gain insight into participants’ perspectives and experiences related to organizational compassion. Before the interview began, all participants signed an informed consent form (see Appendix D) and answered a short series of demographic questions via the survey platform Qualtrics. Per the recommendation of the Institutional Review Board at Arizona State University, each interview also began with a brief discussion of free emotional support resources available to healthcare workers. This information was shared verbally, and participants could also receive an email with the list of resources at their request.

Recognizing that interviews are often spaces of intimate disclosures (Ellis, 2007) and that compassion could be a sensitive topic for healthcare workers, interviews were conducted in one-on-one formats. Interview questions were open-ended to give participants the flexibility to choose their own words (Ellingson, 2017) and the space to revise and omit the details of their stories (Ellis, 2007). To further encourage a sense of participant power and comfort, I utilized an interview stance of deliberate naïveté to demonstrate an openness to unexpected findings (Tracy, 2020).

Ideally, interviews would have taken place in-person in the interest of maximizing nonverbal immediacy and building rapport with participants (Ellingson, 2017). However, respecting CDC guidelines related to COVID-19 and the increasingly busy schedules of
healthcare workers, I conducted interviews via the Zoom computer conferencing application. Allowing participants to interview in the comfort of their own homes has previously been defended as a participant-centered form of data collection (Ellingson, 2017), and I found that my participants appreciated having a private and familiar space to discuss their stories. Other benefits of technologically mediated interviews include cost-effectiveness, increased engagement, and a feeling of safety for participants who may otherwise be shy in person (Tracy, 2020).

After 12 interviews, the interview guide was slightly altered to include an additional question reflecting an emergent theme in the data (see Appendix C). One participant shared that she and her coworkers co-constructed a discursive space called “spiral time” to allow others to vent for a brief window in the day. Struck by how this action simultaneously enabled and constrained compassion, I revised my interview protocol to briefly describe the idea of “spiral time” and ask participants if they had encountered any similar communicative phenomenon in their organizations.

In total, I conducted 27 interviews with a variety of healthcare workers. Interviews ranged from approximately 47 to 76 minutes in length ($M = 62.33, SD = 8.87$). All interviews were video- and audio-recorded. Recordings were professionally transcribed and checked for accuracy, resulting in approximately 485 double-spaced pages of transcript data.

**Participant Demographics**

All participants matched the United States Labor Department’s definition of a healthcare worker (Stephenson, 2020). The sample ($N = 27$) included 21 women, five men, and one nonbinary person. Participants’ age ranged from 24 to 61 years, with an
average age of 35.96 years ($SD = 10.73$). Most participants identified as White or Caucasian ($n = 18; 66.67\%$), but the sample also included participants who identified as Asian American or Pacific Islander ($n = 4$), Hispanic or Latino/a ($n = 2$), Black/African American ($n = 1$), Afro Latina ($n = 1$), and Middle Eastern ($n = 1$).\(^1\) Reflecting the nature of a maximum variation sample, occupations varied among participants, including registered nurses ($n = 6$), nurse practitioners ($n = 5$), technicians ($n = 3$), physical therapists ($n = 3$), administrative workers ($n = 3$), physician assistants ($n = 2$), mental health practitioners ($n = 2$), a physician ($n = 1$), a pharmacist ($n = 1$), and a registered medical assistant ($n = 1$). Participants were located across 13 different states in the United States. Most participants worked in urban areas ($n = 18$), but some participants worked in suburban ($n = 8$) or rural areas ($n = 1$).

On average, participants had worked at their current organization for roughly 4 ½ years ($M = 52.56$ months, $SD = 34.40$ months). Participants also reported their perceptions of how many levels were between them and the highest and lowest decision makers in their organization. Participants reported perceptions of being about 3 levels away from the highest decision maker in their organization ($M = 3.17$, $SD = 1.59$), and about 2 levels above the lowest level in their organization ($M = 2.39$, $SD = 1.79$). In other words, participants often considered themselves as mid-level decision makers in their organization, and many reported supervising others in both formal and informal capacities. Participant household incomes ranged between $30,000 to $150,000+$, and

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\(^1\) Recognizing the largely White and Western sample in this study, it is important to note that this study’s exploration of organizational compassion is reflective of a U.S. Western perspective on compassion and emotion. Future work might be conducted in the global south and other non-western contexts to provide a richer perspective of the co-construction of compassion and different cultural norms regarding compassion.
37.0% of participants \((n = 10)\) possessed a household income between $100,000-$149,000.

All participants were assigned pseudonyms to protect participants’ confidentiality. Pseudonyms were created with a random name generator.

**Data Analysis**

The present study utilized a phronetic iterative approach, where data collection and analysis were both guided by a combination of preexisting theory and emergent qualitative data (Tracy, 2020). This approach allows for abduction, a “cognitive logic of discovery” (Reichertz, 2010, p. 16) where surprising data drives a search for theory, and new theory brings the researcher back to the data. A phronetic iterative approach provides space for playfulness and surprise as researchers engage with the theoretically expected and unexpected (Galman, 2017). To nurture opportunities for surprise and demonstrate a commitment to phronetic iterative analysis, I employed several overlapping steps throughout data collection and analysis. Although these steps may suggest a sequential order, a phronetic iterative approach is nonlinear and I alternated freely between data and theory throughout the research process (Tracy, 2020).

First, I checked the accuracy of all transcriptions, which allowed me to thoroughly immerse myself in the qualitative data. While revisiting my interview data, I loosely held onto sensitizing concepts related to organizational compassion (e.g., Dutton et al., 2006; Kanov et al., 2004; Way & Tracy, 2012) and structuration theory (Giddens, 1984). Second, I often revisited the audio recordings of interviews and engaged in memo-writing as “an interactive space and place for exploration and discovery” (Charmaz, 2014, p. 170). These memos were written in narrative or freeform styles of writing as I noted
points of interest in my data and asked questions to my future self. Third, I regularly spoke with my dissertation advisors about notable stories and emergent findings, creating an additional space for data immersion and sensemaking (Tracy, 2020). Finally, I engaged in primary-cycle and secondary-cycle coding to distill and reorganize my data into meaningful codes.

To maximize my focus on codes relevant to my research questions, I began with a data reduction process using a lens of structuration theory (Giddens, 1984), particularly focusing on concepts of structure and agency. Early on in my coding process, I adopted a stance of “pragmatic eclecticism” to keep myself open to the coding method(s) most suitable for my data rather than enter with a predetermined toolset (Saldaña, 2016). This stance resulted in a combination of descriptive coding and in vivo coding during my primary cycle, where I coded both topics and verbatim vocabulary to begin making sense of my data (Saldaña, 2016). In the primary cycle of coding, I used the reduced data to identify codes. If a piece of data did not fit within a previously established code, I created a new code. I continued this process until no new codes emerged.

In the secondary cycle of coding, I focused on axial coding to reassemble my fractured data (Charmaz, 2014) and organized my initial codes under second-level hierarchical codes (Tracy, 2020). In doing so, I moved toward a deeper understanding of the relationships between my codes and how my qualitative data addressed my overarching research questions. Both primary cycle and secondary cycle coding occurred in Nvivo qualitative software. Finally, recognizing that writing can be a method of inquiry (Tracy, 2020), I remained open to the possibility that my codes could change or
converge during the process of writing my findings. The final codebook is provided in Appendix E.
CHAPTER 3

FINDINGS

Qualitative data from semi-structured interviews revealed that multiple structures in healthcare organizations enable and/or constrain compassion in the workplace. Data indicated that these structures often halt the compassion process at different stages, making it difficult for healthcare workers to recognize, relate, and (re)act to others in pain and suffering. While the following findings section separate structure and agency to answer RQ1 and RQ2, it is important to note the theoretical underpinnings of structuration theory, such that the duality of structure indicates that structures and agency are constitutive of one another (Giddens, 1984). Structures enable and constrain action, and workers (re)produce and transform the structures that guide organizational life (Giddens, 1984).

The first section addresses RQ1 by outlining the specific structures that enable and/or constrain compassion in healthcare organizations. These structures include: (a) healthcare norm of emotional suppression, (b) alone-together workspaces, (c) occupational challenges, (d) the business model of healthcare, (d) disconnected decision-makers, (e) occupational norms of appreciation, (f) access to therapy and mental health resources, and (g) limited access to material resources. Recognizing that these structures have been constituted and maintained through communication, the second section responds to RQ2 and identifies how healthcare workers (re)produce or transform structures of compassion. These individual agentic acts include: (a) asking “how are you?” twice, (b) sharing workload, (c) embodying aboutness, and (d) finding humor in pain. Interestingly, participants also describe collective agentic acts of compassion,
including: (a) making and giving food, (b) donating PTO or ETO, (c) creating informal committees, and (d) limiting spiral time. Additionally, this section highlights how healthcare workers model compassion and practice self-compassion. The final section focuses on the recursive relationship between structure and agency using a specific exemplar of workloads in healthcare. This exemplar reveals how healthcare workers’ compassionate actions and managers’ endorsement can sometimes (re)produce a (non)compassionate structure.

**Structures that Enable and/or Constrain Compassion in Healthcare**

This section describes the structures in healthcare organizations that enable and/or constrain organizational compassion. Specifically, participants identified structures in their organizations that affected the sub-processes of communicating compassion (Tracy & Way, 2012): (a) recognizing (e.g., healthcare norm of emotional suppression, alone-together workspaces, occupational challenges), (b) relating (e.g., the business model of healthcare, disconnected decision-makers, occupational norms of appreciation), and (c) (re)acting (e.g., access to therapy and mental health resources, limited access to material resources) to suffering in others.

During data analysis, I found that the stories and experiences of my participants highlighted different stages of the compassion process, which served as the organizational framework for this section. However, this framework is not to say that each structure influences one and only one subprocess of communicating compassion. The subprocesses of compassion are not mutually exclusive and often co-occur (Way & Tracy, 2012). Therefore, the following findings may be better considered an analytic snapshot of the ways that structures enabled and/or constrained compassion in the lives of
Structures that Enable and/or Constrain Recognizing Suffering

Healthcare Norm of Emotional Suppression

The first and most frequently identified structure that enabled and constrained recognizing suffering within the data was the healthcare norm of emotional suppression. Participants said they felt socially and professionally obligated to mute any emotions of suffering in the workplace, even though healthcare organizations are rife with situations that could cause emotional distress. Although some participants connected this norm to a need for privacy, most participants discussed emotional muting as a form of strength. William, a 29-year-old emergency medical technician, explains:

Amongst each other we try to be very tough, but also in front of the patients. I'm not sure it would be good for them to see us express those emotions, but we still feel the need to be strong and not show those emotions.

By using “we” language, William suggests that this healthcare norm applies to not only him but to all of his coworkers. Furthermore, William expresses doubt about the “good” and usefulness of expressing emotions, which reflects the desire for rationality common in healthcare (Dutta, 2008). However, this norm of emotional suppression is paradoxical, given that healthcare work is inherently technical and emotional in nature (Hafferty, 1988). Additionally, this structure presents a barrier to recognizing suffering in others, which is the first subprocess of compassion. By stifling their emotions both verbally and nonverbally, healthcare workers hide the communicative cues that could signal a need for
compassion from others (Way & Tracy, 2012).

Even in difficult situations, such as when William and his coworker spent almost two hours doing CPR on a young patient, William explained that he felt the need to hide his emotions. Following the event, William and his coworker took a brief “moment” in the locker room to allow themselves to become “teary-eyed” with no one around, but only a moment. William shared: “Then we came out and just had to pretend that everything was cool…We don’t want people to think we can’t handle what’s going on around us.” Like William, many other participants were worried that emotional displays would signal incompetence to their coworkers and patients.

Similarly, some participants described their commitment to emotional suppression using colorful metaphors. Lucas, a 28-year-old resident physician, envisioned the kind of healthcare worker he wanted to be:

The goal is to be like a rock and a river. Like someone who's very sturdy and can be looked to, but also someone very flexible and can kind of go with the flow and can have the perseverance of both. Like a river, you keep chipping away at the same thing and going forward, but also like the perseverance of a rock and that you're very stoic.

Here again, the notion of strength and stoicism is captured in Lucas’ goal to be like a rock and a river. Lucas also highlights the key mechanisms that drive strength, such as flexibility and perseverance in the face of hardship. Importantly, Lucas also comments on how he wants to be someone who “can be looked to,” indicating his awareness that his coworkers are likely observing his ability to emotionally regulate. In this metaphor, there is no allowance for the rock and the river to experience setbacks, only a pressure to keep
“going forward.”

Other common language that participants used to describe the norm of emotional suppression include “bottling up,” “powering through,” “pushing aside,” and “keeping the lid on” emotions at work. Daisy, a 39-year-old nurse practitioner, intentionally suppressed her emotions, saying: “Sometimes I will leave those bottled up inside and not let it out, and then I'll let it out in a very non-professional way, or try and not let some of that bother me.” In Daisy’s case, she would bottle up her emotions until she could return home and share her stressors with her husband. Taken together, data indicated that healthcare workers often strive to mute feelings of stress, sadness, and anger in favor of appearing strong, stoic, and unaffected by emotional experiences. As a result, healthcare workers may be unable to recognize suffering when it is masked under the guise of strength. Therefore, the occupational structure of emotional stoicism in healthcare limits the space for wearing and sharing emotions at work.

_Alone-together Workspaces_

A second structure that enabled and constrained recognizing suffering was alone-together workspaces (i.e., physical spaces which made healthcare workers feel both isolated and connected with coworkers). During the interview, participants were asked to envision and describe an ideal workspace that feels compassionate to them. Participants articulated that simple design choices in workers’ physical environments affected the likelihood of engaging in emotion-sharing conversations with coworkers. Therefore, certain environments enabled and/or constrained participants’ abilities to witness and recognize suffering, which subsequently influenced the process of compassion. Theodore, a 51-year-old clinical coordinator, expressed gratitude for his workspace. Theodore
describes his workspace as follows:

I mean, we have our teams located in... They're called pods. It's a completely open
office. So there's pods separated by walls. And then each team has several walled
off cubicles but it's an open area so everyone can see each other. I like that style
for myself: being able to turn around and be able to see someone if I need to, just
reach out and call someone, not to have a closed-off cubicle and have to walk
over to them and knock on the cubicle or anything and seeing if anyone's there.
And so, I like being able to have everything open where everyone's talking to
each other, social, joking around a little bit.

In Theodore’s workspace, the open floor plan and walled-off cubicles provide
opportunities to easily converse with coworkers or seek privacy, respectively. These
design choices empower Theodore to choose where and with whom to express emotions
and suffering, if at all. However, most participants could not match Theodore’s
enthusiasm for his workspace. Instead, many participants found their workspaces to be
constraining. Lucas, a 28-year-old resident physician, shared his critique of his hospital’s
rounding room:

The way the computers are set up right now, you have a room and they're set up
logically along the walls. So that way they take up minimal space and they can get
all the outlets and everything like that. But I like the idea that we've talked about
before: flipping the script and instead have all the computers face each other. So
you're looking at each other the whole time you're working instead of looking to
the left to see somebody or looking at everybody's backs or sitting behind them.
Lucas’ workspace was clearly designed with practicality in mind, mostly in relation to
electrical outlets. Lucas’ suggestion to “flip the script” and change one feature of his environment is a simple solution that would enable opportunities for social interaction. Indeed, recognizing others’ suffering presumes that workers can physically observe and interact with one another. When healthcare workers see each other’s backs instead of each other’s faces, conversations may be less likely to occur, and nonverbal cues of distress may be missed.

Participants were clearly observant of the materiality of their organizations. Beyond commentary on seating arrangements and openness of floor plans, participants also shared their preferences related to lighting, windows, art, and specific objects or furniture they desired in an ideal workspace. Common examples include calls for “softer lighting,” “large windows to see the outdoors,” “brighter colors for walls,” “comfortable chairs,” “couches,” and “fridges.” Although environmental preferences could vary widely among participants, the justification behind these design choices were related to increasing a feeling of comfort and connection when interacting with coworkers.

Participants who did not have an ideal workspace— if they had such a space at all—still found ways to utilize the spaces around them for conversation and reprieve throughout the day, but almost all participants could easily name several suggestions to improve their physical environments.

**Occupational Challenges of Healthcare**

**Overwhelming Workload.** Participants identified a multitude of occupational challenges unique to healthcare, but the structure of overwhelming workload is especially relevant to the subprocess of recognizing suffering in others. Almost all participants described their workload as “overwhelming,” both in quantity of tasks and expertise
needed to carry out those tasks. Moreover, participants described how they perceived little to no control in the design and order of their work schedules, suggesting that overwhelming workloads are a structure of domination in healthcare. Although healthcare workers are the technical experts of their field and are better equipped to estimate how long a task may take, administrators and managers maintain control of workloads and schedules to maximize productivity in the organization.

Given that recognizing is an active and effortful aspect of the compassion process (Way & Tracy, 2012), processes that monopolize the cognitive loads of healthcare workers may prevent the compassion process at its inception. Overwhelming workloads means seeing more patients at an unsustainable speed, which leaves little time for conversations with both patients and coworkers. Reflecting on a difficult holiday season, 27-year-old registered medical assistant Emma described her “exhausting” workday where she would “see 30 patients, call in all the prescriptions, do all the referrals, do all the prior authorizations, return all of [the] phone messages” and more.

Like Emma, many participants felt their job had become a stressful series of tasks rather than a space to realize a passion for helping others. Many participants reported that their overwhelming workloads were testing their job engagement. Audrey, a 27-year-old registered nurse, shared that her workload was affecting her energy and excitement at work:

I still feel like this is my career path and I'm in it for a reason, but it does get harder. It has been getting harder, especially when it's like you have all these crazy sick patients and it's just super stressful and everyone's stressed out. As far as being disengaged, I still feel like I'm able to give my patients what they need
and my coworkers what they need, but there are definitely nights where I just kind of shut down. I just need to step back and maybe go take a break or go sit outside for a minute and kind of catch myself from coming apart, just because it's so crazy busy or stressful.

Audrey’s experience resembles the stories of many participants who said they were approaching or had already reached their “breaking point.” Audrey’s commentary also showcases how overwhelming workloads can reinforce the healthcare norm of emotional suppression, such as when her workload causes her to “shut down” and physically remove herself from the workplace. If healthcare workers withdraw as a way to survive their workload, the opportunity to share emotions and recognize suffering among coworkers is limited.

Finally, participants shared that an overwhelming workload could cause other priorities to shift. Oliver, a 30-year-old physical therapist, explains how he feels pressured to prioritize his work:

I feel I'm always on the clock in a way. I'm just always in work mode…There's pressures from [management] just to always put work first over everything. Trying to maintain that dynamic of maintaining a good rapport [with my manager and coworkers] and being a hard worker while also maintaining a good work-life balance can be a challenge.

The feeling of always being “on the clock” suggests that Oliver struggles to segment his work and personal life. Accomplishing his workload to uphold the image of a hard worker, maintaining workplace relationships, and protecting his personal life were all important to Oliver, but balancing competing interests often left Oliver feeling like he
was “burning the candle at both ends.” Overwhelming workloads may leave healthcare workers feeling like they must choose between the task and relational aspects of their work.

**Telemedicine and Telehealth.** Another occupational challenge that constrained the subprocess of recognizing was the shift to telemedicine and telehealth during the global pandemic. For many participants in this study, other than those who worked on the emergency room floor or in highly specialized fields, work became virtual (ranging from several months to a year). Theodore, who has worked as a clinical coordinator for over nine years, reflected on this shift:

> When COVID hit, everything changed. Everything was done by phone. I would do all my meetings by phone, contact with members by phone. I'd have meetings with the other supervisors or clinical teams to update the demand, what's going on with the hospitals. So all the case managers were pretty much working from home.

In Theodore’s case, phone calls replaced face-to-face interactions, dramatically changing the way he communicated with his supervisors and coworkers. Theodore’s coworkers were not as easily accessible as they once were when he could simply walk down the hall and chat with anyone. Although some technology, such as video conferencing platforms, provide opportunities to recognize verbal and nonverbal cues of distress in others, technology-mediated communication is leaner than face-to-face communication. Recognizing suffering in others is not impossible in virtual settings but identifying and sensemaking the context for communicative cues may become more challenging when messages are asynchronous.
Both healthcare workers and their patients had to adjust to an increased reliance on technology in the face of COVID-19. While most participants bemoaned the new “responsibilities” and “challenges” of telehealth (e.g., teaching patients how to use Zoom), some participants welcomed the change. Valerie, a 32-year-old behavioral analyst, said that she enjoyed teleworking because “it’s easier to put up with more bullshit” during staff meetings. Reflecting on how sometimes management annoyed her during meetings, Valerie explains: "I don't have to look at your face while you're talking to me and making me angry [when we’re meeting on Zoom].” In this example, the lean nature of telework constrains recognizing because workers can easily disengage from social interaction by muting themselves or others. Conversely, it could also be argued that the potential privacy of telework allows workers to strategically choose when and with whom to share their emotions.

**Structures that Enable and/or Constrain Relating to Others**

**The Business Model of Healthcare**

One structure that constrains relating in the compassion process is the business model of healthcare. The business model of healthcare refers to a common style of management where decisions are largely driven by finances. Participants identified “money” and “business” as the main priorities of their organizations, and they noticed the ways that managers acted in the interest of cost reduction rather than healthcare workers’ wellbeing. For example, Grace, a 47-year-old registered nurse explained, “[Organizational power holders] are looking at the bottom-line. They're looking at money. They're looking at how much this is costing us, where it's really truly costing people's mental health.” Some participants were resigned to this focus on the bottom-line,
believing it to be a characteristic of the healthcare industry in general. For example, Taylor, a 36-year-old charge nurse, explained:

And I know this is not unique and that's why I haven't left my organization…is that you feel like administration, especially higher-up administration or corporate, they're up for money. They don't really care about us. They don't really care about the patients unless it affects the bottom-line or their outcomes. They want their outcomes to look good.

Such comments are indicative of a relational rift between managers and the average healthcare worker. Differing priorities can make it difficult to create the consubstantial and cooperative relationships necessary for relating to occur (Way & Tracy, 2012). As George, a 58-year-old physician assistant, explains, “Sometimes all they see is dollar signs and then I'm concerned about the patient in front of me.” Relating requires a sense of identification between two parties (Way & Tracy, 2012). However, participants often found it difficult to understand management’s focus on finances. Many participants felt that financial concerns were in direct conflict with a person-centered approach in healthcare.

Management’s devotion to a business model in healthcare also introduced a sense of job insecurity in many participants who wondered if they would be fired if they could not meet expectations. For example, Brooke, a 24-year-old pharmacy technician, explains:

[Management] is crunching numbers, and it feels like we’re just another number. And we have to meet this certain number or else our job feels threatened or the security of our job is on the line. As an organization, as an institution, I don't think
there's any compassion there…If you’re feeling upset or burnt out at work, there's no advice for council or ways to make it better or bonding experiences or anything like that. I just feel like that is on the bottom of their priority list.

Brooke’s comment points to two important areas where management could demonstrate empathy and relate to employees’ stress but fail to do so. First, recognizing and openly addressing feelings of job insecurity could communicate that management views employees as humans rather than numbers in an organization. Second, Brooke notes that her managers do not legitimize feelings of stress or burnout through advice or action. Interestingly, Brooke mentions that “bonding experiences” might alleviate stress by encouraging coworkers and managers to learn about one another and build systems of support at work, which would also increase the likelihood of relating between the two parties.

**Disconnected Decision-makers**

Beyond tensions related to the bottom-line, participants identified a feeling of “disconnect” whenever management and administration communicated decisions and policy changes. Sophie, a 38-year-old nurse practitioner, suggested that feelings of disconnect are borne from hierarchical distance: “I think big organizations, the hard part about it being compassionate is that you're having people make decisions who are so far away from you. And they're the ones who are really delegating what happens to you.” Without evidence of perspective-taking, several participants argued that management could not effectively relate to their pain. Valerie, a 32-year-old behavioral analyst, described her upper management as “judgmental,” especially at times when managers and administrators were “trying to tell the staff how to do their jobs without really
knowing what the jobs are, who the clients are, and how the clients function on a daily basis.”

Participants were especially frustrated when their managers demonstrated a lack of perspective-taking and a lack of empathic concern, both of which are key components of relating (Way & Tracy, 2012). For example, Helen, a 51-year-old pharmacist, described her managers as “fake” and further stated:

They make their decisions in their comfy chairs in the offices and their fancy lunches when they meet, and they come up with a decision that they did not even see if it’s worse in the workplace or not…They are disconnected completely.

They don't have anything to do with the real workplace.

Helen suggests that her managers’ world of comfort is a stark contrast from the “real workplace.” Helen later joked that her managers’ job descriptions must have included a rule like “do not show emotions,” given how unempathetic they were. If empathy is not perceived in interaction, relating cannot effectively occur. However, some participants believed that managers could nurture more empathy if they participated in job shadowing and witnessed subordinates’ daily struggles. Samantha, a 31-year-old inpatient psychotherapist for children, shared:

It would be really nice to see some of these higher-ups come and spend a day on one of our units, where we've had to restrain several kids, where we've had to pick up a kid off the floor because they're sobbing because their parents just said, “You can't come home, we don't want you anymore.” I challenge any of the higher-ups to come and participate in that because they feel so far removed from the compassion that is necessary on our units.
Samantha wanted her managers to not only witness her overwhelming workload, but also feel the stress and heartache that characterized her work. Samantha’s argument reinforces the idea that relating is both a cognitive and affective skill, grounded in mental, emotional, and communicative efforts to understand another person’s suffering (Way & Tracy, 2012).

**Occupational Norm of Appreciation**

Displays of appreciation demonstrated potential to both enable and constrain relating between healthcare workers and their managers. Participants described an occupational norm in healthcare where messages of appreciation were frequently communicated yet felt “hollow” and “not genuine.” Even when managers verbally expressed gratitude to employees—perhaps in their own attempt to relate to healthcare workers’ hardships—words often fell short of expectations. Reflecting on whether or not she felt appreciated in her workplace, 29-year-old registered nurse Elaina explained:

> I think they try by sending us emails saying, "Good job, team. You're doing great," which is nice. But when they say the same thing in every email, it just seems a little bit not as genuine, so that is kind of disheartening.

For Elaina, the “genuineness” of manager communication was a key factor in whether she felt appreciated. A compliment like “good job” may feel insincere because it does not address the specific challenges and suffering that healthcare workers face in their daily lives. In other words, platitudes do not provide evidence of thoughtful perspective-taking or empathy. Oliver, a 30-year-old physical therapist, said that specificity in “positive reinforcement goes a long way to making workers feel they’re seen and heard.” Oliver explained that his manager would occasionally display “bouts of compassion” by “giving
very personable, detailed, written-out examples of why and how he appreciates me and all the good things I’m doing.”

Throughout data collection, it also became clear that participants felt a difference between words of appreciation and acts of appreciation. Caroline, a 33-year-old paramedic technician, neatly sums up this difference:

I think that it would be nice if they were able to— I don't know exactly how— but show their appreciation more, because they know what's going on and they know how hard we're working. They say it through emails or through these text messages. They say, "Thank you so much for helping us. We really appreciate it," but they're not exactly showing it. Maybe they think they're showing it because we are getting really good incentives and being paid more for working these shifts, which is really nice, but that's not all that matters. So, I don't know what that would look like…if it were like buying us lunch once in a while, or, I don't know, giving us a gift bag. I don't really know, but something to show it, because they don't show it. They just say it.

Again, Caroline’s example points to a phenomenon where words of appreciation are perhaps necessary but not sufficient in conveying a shared understanding of suffering. Furthermore, this data suggests that messages of relating may lose their potency or even backfire if healthcare workers do not see evidence of (re)acting. Healthcare workers are not only looking for messages of thanks; they are seeking evidence that management cares about healthcare workers’ wellbeing enough to make changes in material structures (e.g., pay, benefits, time off, etc.).
Structures that Enable and/or Constrain (Re)acting

Access to Therapy and Mental Health Resources

Almost all participants could name resources available to them through their organization, including: free or discounted counseling, wellness coaches, dieticians, crisis hotlines, and subscriptions to online meditation applications. Arguably the face and heart of compassion (Way & Tracy, 2012), (re)acting to others’ suffering can take many forms. In the context of healthcare, where rates of stress and burnout are especially high, structures that provide access to therapy and mental health resources are important. Such resources can be both proactive and reactive to healthcare workers’ struggles. In regard to therapy, some participants could utilize counseling services an unlimited number of times, whereas other participants had a limited number of paid sessions. Some organizations also have employee support groups to connect employees who are struggling with similar issues.

Despite the variety of mental health resources available, most participants admitted that they did not utilize them. Two primary explanations emerged to describe this pattern among participants. First, many participants said they did not have the time to take advantage of mental health programs and services. Caroline, a 33-year-old paramedic technician, explains:

The hardest part about using those resources is just finding the time to. They have all of these things, but they don't necessarily make time for us to go there. Nobody wants to be there longer than 12 hours, so I don't know a lot of people that use them.

Healthcare workers’ schedules did not always provide a practical time for therapy. Alex,
a 28-year-old physical therapist, was initially interested in their organization’s employee support group but discovered that the meetings overlapped with their work hours and would require time off. The irony of Alex’s case is borne from conflicting structures in healthcare: one structure that communicates “open” access to mental health resources and one structure that perpetuates overwhelming workloads and a schedule that essentially blocks access to a helpful resource.

A second explanation for participants’ low participation in mental health programs is the stigma around mental health. Emma, a 27-year-old registered medical assistant, pointed to her organization’s poor messaging for mental health resources:

Sometimes it can be presented in a negative way, like, "There's something wrong with you. I think you need to go talk to somebody" instead of, "We have these resources, if you need them."

Participants were sensitive to the ways in which mental health resources were framed. Given that healthcare workers are deeply committed to displaying strength and muting emotion, it is crucial for organizations to communicate safety when presenting mental health resources. Again, compassion does not necessarily have to be a reaction to pain (Way & Tracy, 2012); it can also be anticipatory (Tietsort, 2021). Providing mental health resources in a nonjudgmental way would be an excellent demonstration of proactive compassion. As Emma indicates, it may be more helpful for organizations to frame resources as “readily available” rather than a fix for the distressed worker. Participants suggested that the timing of such messages are also important, and participants were generally more receptive of resources when they were proactively offered. Oliver, a physical therapist, explained that he felt good about pursuing resources
because his managers frequently communicated messages such as “If you need anybody to talk to, we have these resources, you can always come to us.”

**Limited Access to Material Resources**

Participants described how current structures in healthcare provide limited access to material resources, which constrains managements’ ability to effectively (re)act to expressions of suffering in the workplace. Participants identified tangible resources that their organizations could provide to alleviate employees’ stress and pain in the workplace. Among these suggestions, many participants wished for a surplus of medical supplies (e.g., personal protective equipment, sanitizer, patient beds, machines, etc.) but they also recognized that supply shortages were a widespread issue in healthcare during COVID-19 and not necessarily within managers’ control. As such, participants turned their attention to other material resources that could potentially be addressed through intentional efforts and changes in the organization.

**Turnover and Staffing.** One of the most important material resources in any organization is the employee population itself, and healthcare is no exception to the need for skilled bodies. High turnover rates are common in the healthcare industry (McSherry & Pearce, 2018)–so common that many participants wanted their organizations to respond to this need proactively by overstaffing. William, a 29-year-old emergency medical technician, describes the benefits of overstaffing:

I think the most helpful thing they could do is overstaff, which sounds ridiculous. But it's almost guaranteed we're going to have at least one person call out every day. But to have adequate staff is not to have all the slots filled, it's to have more than you need. It's such a mood booster when you have somebody floating
around, and they're like, "What do you need? What can I help you with?" Just having an extra person. Even if you did the numbers and they weren't actually doing that much more work, the mood boost it gives you is so much more worth it than whatever work they're completing. I think people would be willing to work harder or longer, or just feel better at the end of the day if we had that.

Here, William identifies both the practical and emotional benefits of overstaffing. Some organizations provide a sense of overstaffing through a float system. “Floaters” are healthcare workers (often in training) who do not directly oversee patients but instead help wherever they are needed throughout the day. Such a system proactively recognizes and responds to a common stress in healthcare.

The consequences of turnover are not limited to a lack of workers. Healthcare workers are not only skilled medical professionals; they are often the coworkers, friends, and sources of comfort that people associate with their workplace. As turnover increases in the face of COVID-19, in part due to the lucrative nature of travel nursing, healthcare workers are feeling the loss of social relationships. Zoey, a 28-year-old registered nurse, explained: “The people that we did have on the unit, a lot of them were leaving for travel contracts. So, a lot of people on the units are now people that are also travelers that we don't have a relationship with.” Building meaningful relationships with coworkers can take time, and such relationships may seem difficult to form when some workers, like travel nurses, are only present for a limited time. If coworkers are strangers to one another, (re)acting to a suffering colleague may be less likely to occur due to a lack of relational history and relational investment.

**Food.** Food is a basic necessity, but many participants felt that their organizations
underestimated the importance of food as a way to communicate compassion. Hazel, a 61-year-old clinical supervisor, explained that her hospital did not offer basic “creature comforts:”

You can't get a hot meal on the weekends anymore anywhere. They have prepackaged sandwiches, and it makes it really difficult. So, you either have to bring food in from home or you wind up ordering out. It used to be that you could get hot breakfast. I mean, there are nights when I go in and I work four PM to four AM, and I've worked the night before, so I've come home and I've slept. And I got up for work at three o'clock, took a shower, threw my scrubs on and I can't even go down to the cafeteria and get a bowl of soup when I get there.

For Hazel, a hot meal is both about setting her up for a successful day and recognizing her efforts from the previous day. Other participants who worked the night shift like Hazel also commented on the lack of hot food available to them (e.g., “hot breakfast,” “soups,” “burgers,” and “pizza”). Participants expressed dissatisfaction when the only food options available at work were cold meals such as “prepackaged sandwiches.” This may be because hot food on a plate suggests a greater amount of preparation and thoughtfulness than cold foods that can be quickly made and wrapped in plastic. Additionally, some participants associated hot meals with the image of “sitting down” and enjoying a meal as opposed to being on the move and “shoveling food” in one’s mouth.

During interviews, participants described food as a necessary meal and a potential reward from managers. When asked what her organization could be doing better to manage employee suffering, 24-year-old pharmacy technician Brooke responded with an
example:

There's a lot that they can do on their end to make the workplace better…So there's a whole day designated “Pharmacy Technician Day,” and they gave us an old pin that was just a pin that you can put on your scrubs. And I'm just like, "Dude, order a pizza or something." There was no food given.

Although mass-ordering pins for technicians in Brooke’s organization (which has thousands of locations and hundreds of thousands of employees across the United States) was likely a sizeable investment, it is clear from Brooke’s explanation that “an old pin” was not an effective way to (re)act to stressed employees. In this example, upper management may have thought that a pin would be an enduring gift rather than a temporary gift like food. However, food possessed more meaning to participants because it was a specific (re)action that acknowledged workers’ chaotic schedules. Participants worried about how they would get their next (or only) meal during a busy shift, and they welcomed times when they could set that worry aside. Although a pizza may seem simple and relatively inexpensive compared to a pin, participants considered food to be a thoughtful gesture and effective way of communicating care. Outside of “hot meals,” the most commonly mentioned foods in interviews were “coffee” and sweet treats like “doughnuts” and “ice cream.”

The Structuration of Organizational Compassion

To summarize the main findings of this section, Figure 1 illustrates the structuration of organizational compassion in healthcare organizations. At the core of this figure is the compassion process, where recognizing, relating, and (re)acting are concurrent processes that can continually feed into one another. Echoing Way and
Tracy’s (2012) model of the compassionate heart, this model also supports the notion that compassion is not always a linear process; bidirectional arrows indicate that the subprocesses can double-back. Rather than portray the compassion process in the boxes and arrows typical in emotion scholarship (Way & Tracy, 2012), this model uses triangles to indicate how the (re)production of certain structures constrain the compassion process. The (re)production of constraining structures listed at the bottom of this figure, which narrow and taper each subprocess of compassion, are evidenced by the data of this study. On the other end, select structure (re)production in healthcare enables the compassion process; the bases of the triangles are intentionally positioned to illustrate how the (re)production of certain structures can “widen” the possibility and space for compassion processes to occur.

Figure 1

Summary Model of the Structuration of Organizational Compassion
Most notably, this figure illustrates how the (re)production of structures in healthcare largely constrain compassion. Although structures can be simultaneously enabling and constraining (Giddens, 1984), participants of this study mainly described how the rules and resources in their organizations inhibited recognizing, relating, and (re)acting to suffering. Overall, this figure demonstrates that (re)produced structures in healthcare consistently mute compassion. However, as the next section describes in more detail, healthcare workers still seek opportunities to engage in the compassion process despite the structures that may constrain them.

**How Healthcare Workers (Re)produce and Transform Structures of Compassion**

Recognizing that structures are not external to the actions of individuals (Giddens, 1984), the second research question of this study focuses on how healthcare workers (re)produce and/or transform structures of compassion in their organizations. Although workers are not always cognizant of their agency, workers have the potential to reinforce or alter the status quo in the workplace (Giddens, 1984). All actors have agency, but not all actors have access to all the options and resources of structures, particularly workers in low authority positions (Zanin, 2018). This section outlines the various ways in which healthcare workers (a) act compassionately as an individual, (b) coordinate compassion as a collective, (c) model compassion, and (d) practice self-compassion. Together, these findings demonstrate that healthcare workers seek and create opportunities to engage in the compassion process, sometimes reproducing the same structures that constrain compassion.
Acting Compassionately as an Individual

Participants described multiple ways that an individual could recognize, relate, and (re)act to coworkers who are suffering. The following subcodes consist of the most common compassionate practices occurring at the individual level.

* Asking “How Are You?” Twice

The majority of participants agreed that the compassion process was initiated often with the simple question of “how are you?” For Daisy, asking others “how are you” was a part of her daily routine as a nurse practitioner. She explains:

> I do feel like I am able to really read people fairly well when they need to talk more. If I ask a patient or if I ask one of my co-workers, "How are you?" and their answer is a little bit withdrawn, then I ask again, "How are you?" And then typically in that second question, I'll get more truth to their response with either tears and, "I'm not okay." But if they're like, "Nope, I'm fine," then I'm going to take their word for it. And then I usually follow it up with, "I'm here if you need to talk."

Like Daisy, several participants mentioned that it was important to ask others “how are you” twice in a row. These participants indicated that the first “how are you” rarely evoked emotion or sincerity out of others, perhaps because greetings can often feel like an empty pleasantry. Moreover, due to the norm of emotional suppression in healthcare, workers’ first instinct may be to mute themselves or withdraw from conversation. By asking a second “how are you,” participants gently and tactfully pushed outside of social norms in healthcare to create space for compassion. Additionally, as Daisy indicated, she would respect her coworkers’ judgment if the second “how are you” did not elicit an
emotional reaction. Daisy’s double “how are you” is a quiet yet effective disruption of expectations created by the structure of emotional suppression.

Many participants referred to “how are you” interactions as intentionally “checking in” with others. Madeline, a 34-year-old nurse practitioner, also committed to checking in with others as part of her “routine:”

I like the idea of people coming around and checking in. We have a lot of nurse practitioners and I'll check in with a couple that go in and out of the hospital, like, "Hey, how are you doing? Can I help you in any way?" So I think having that, I guess that's what you call it, just a check in. Make sure people are... that their head’s above water basically, and if not, well, what do you need?

With their overwhelming workloads and chaotic schedules, many participants were worried about missing nonverbal cues of distress in coworkers, so they verbally checked in with their peers instead. Check-ins enable healthcare workers to recognize pain and combat sedimented structures of emotional suppression, which may then open pathways for relating and (re)acting as well. As indicated in Madeline’s example, a check-in also allows healthcare workers to invite specific actions of compassion from each other with questions such as “Can I help you in any way?” and “What do you need?” Inviting suggestions may alleviate the burden of appearing strong in distressed workers, and it may also be a learning opportunity for healthcare workers who may be unsure what actions can be considered both compassionate and appropriate in their workplace.

**Sharing Workload**

According to participants, one of the most important and practical ways to (re)act compassionately was to share workloads. Sharing the workload of an overwhelmed
coworker was a common practice for almost all participants in the present study. Fiona, a 30-year-old nurse practitioner, explained that sharing workload was about acknowledging that “we’re all human:”

At the end of the day, everyone looks out for each other… If somebody's struggling or somebody can't show up or something, you should never say, "That's not my job." I've been my own medical assistant in the past. I've taken my own vitals on patients. I've taken my own intake. Dude, stuff happens. Life happens. So, everyone needs to be there for each other, have great communication to where people can fill in.

The firmness of Fiona’s claim that one should “never” say no to helping others indicates how normative sharing workload is in healthcare settings. For many participants, sharing workload meant taking on tedious tasks that were not necessarily part of their job description, and this was especially true for healthcare workers at higher levels of authority. Beyond helping a peer, participants motivated themselves to share workloads by considering the times they had been helped in the past and imagining future situations where they may need help. Annie, a 57-year-old family nurse practitioner, explained the nature of this exchange:

I think it's give and take too. Sometimes I need somebody to switch calls with me or like their kids have a football game, they need to leave early, "Can you cover for me?" If I can, I'm going to help you out because I truly feel what goes around, comes around. And if you're going to be helpful to them, when you need help, they help.

Sharing workload is not only about (re)acting in one situation. Sharing workload is also
about building rapport and trust so that compassion might continue to flourish between coworkers in the future. However, sharing workloads also (re)produces the structure of overwhelming workloads in healthcare. From a managed care model perspective, there may be no incentive (i.e., bottom-line reasoning) to address healthcare workers’ overwhelming workload given that healthcare workers are finding ways to meet expectations by sharing tasks.

**Embodying Aboutness**

Participants also discussed the ways they intentionally “wear” a face and body that communicates compassion to others. These examples demonstrate the concept of embodied aboutness, or “making one’s body *about* the other” (Huffman, 2017, p. 159) through presence, immediacy, and acts of service. The data in the present study extend theorizing on embodied aboutness by providing empirical evidence of how this construct unfolds in a healthcare context where emotional suppression is normative. When asked about what compassion looks like in real life, nurse practitioner Daisy responded:

I typically touch all of my patients, whether it’s just a pat on the shoulder or on their back when I leave, or actually giving them a hug. Compassion to me is physical, as well as listening and empathy and caring.

Daisy also shared that she liked to be physically present for her coworkers and supervisors too. However, the closed-off design of Daisy’s workspace sometimes complicated such efforts. Daisy once joked to her supervisor: “I'm going to knock this wall down so that you're like just right there, so that I don't have to... So that we can just talk like that.” Daisy’s experience suggests that embodied aboutness may be more likely to occur in physical spaces where people can easily interact and see one another.
Other participants also echoed the idea that compassion is physical. Valerie, a behavioral analyst, described hugs as a “kind of reassurance” and a “kind of affection” between troubled coworkers. Annie, who has been a nurse practitioner for 25 years, reflected on the compassion she sees in her workplace:

If you're having a bad day, there's always somebody there to give you a hug or like sometimes that we've had a patient that has passed away or something and we can cry together. Just sometimes, like I said, that hug that you need, or even just the “Hi” or “See you later. Have a good night.” Or, “we'll start over tomorrow. Tomorrow will be a better day.”

Although words can be a comfort in times of stress, many participants said that “just being there” was often enough. This data excerpt suggests that embodied aboutness in healthcare organizations might be more muted on a daily basis, but participants were relatively confident that they could find a hug if they truly needed it. As Annie indicated, it is also important to note that healthcare workers may be more likely to embody aboutness and compassion on the “bad days.” Embodied aboutness on “bad days” could be a nonverbal invitation for the emotionally stoic to show themselves grace and share their emotions with coworkers. Grace, a 47-year-old registered nurse, noted that compassion could take many physical and verbal forms, so “you have to learn what the person wants.”

**Finding Humor in Pain**

Healthcare workers are regularly exposed to death and emotionally distressing situations (Aase et al., 2008). Although many participants in the present study identified healthcare as their calling, they were not immune to feeling the emotional weight and
existential dread associated with their work. Recognizing this aspect of their work, participants discussed the ways in which they helped others find humor in the face of pain. Audrey, who has worked as an ER nurse for almost four years, explained the importance of humor at work:

I think a lot of times in the ER, we joke about things that probably shouldn't be joked about. But it kind of just makes it easy to just laugh at a situation that you want to cry about. Because sometimes if you don't laugh, you're going to cry. So a lot of times in the ER, we just goof off as much as we can.

For many participants, humor was a more accessible way to process difficult emotions, and it may have also felt more socially acceptable in light of the structure of emotional suppression in healthcare. Audrey said that she and her coworkers typically wanted to avoid tears, so they filled their days with laughter instead. Finding humor and space to “goof off” is an agentic display of compassion because it contradicts several structures in healthcare (e.g., norm of emotional suppression, overwhelming workload, the business model of healthcare).

Cecilia, a 34-year-old physician assistant, shared that her coworkers were more likely to discuss their struggles in the context of “super dark humor.” Cecilia shared: “There are just dark jokes about depression or just the darkness that you see. A lot of people use humor to express that.” Cecilia’s observation that people joked about their depression coincides with the ambiguous messaging around mental health in healthcare. Such humor may also be related to why the participants rarely sought mental health resources in their organization; if depression can be joked about, it may not merit serious attention or use of resources. Other participants acknowledged that the dark humor
common in healthcare would likely seem “inappropriate” and “a bit jaded” to others due to all the “jokes that probably aren’t funny to other people.” However, participants also defended humor as an important source of levity and distraction in difficult situations. Taylor, a 36-year-old charge nurse, explains:

> Even when it's a terrible night and it feels like things are collapsing around you, there's always that moment where you look at somebody and...we'll just laugh because things are so outrageously ridiculous. So being able to have those moments of comradery and things like that... It's just huge. So I'm very thankful for that.

In Taylor’s example, a specific joke is not told, but coworkers still help each other find humor in the absurdity of their situation. Prior research has shown that nurses use humor to alleviate feelings of anger or anxiety that may arise during difficult situations with patients (Wanzer et al., 2005). In the face of tragedy, humor can be a means of reappraising a difficult situation and making it more tolerable (Tracy & Tracy, 1998). In healthcare, choosing to laugh in the face of hardship breaks social expectations related to emotional suppression and professional in the workplace. However, even if it is for a brief moment, humor provides participants an opportunity to focus on relationship-building and empathy instead of their workloads.

**Coordinating Compassion as a Collective**

In some situations, participants collaborated with their coworkers to recognize, relate, and (re)act to a colleague who was suffering. The exemplars in this section showcase how healthcare workers coordinate collective compassion in the face of exceptional hardship (e.g., death of a family member, illness or surgery, loss of home,
etc.), but participants also developed ways to respond to daily struggles as well.

**Making and Giving Food**

Just as managers can use food to communicate compassion to their employees, healthcare workers used food to (re)act compassionately with one another. Meal trains, an effort where people sign up to provide meals for a colleague and his/her family over a period of time, were often mentioned during interviews. For example, Elaina described how her coworkers came together to support a colleague who had just given birth and was soon after diagnosed with cancer:

> After she had the baby, she found out it was breast cancer. And literally everyone on our unit signed up to babysit her kids and send her food. We had a meal train going for months for her, while she was getting chemo and signing up to babysit her kids, so that when she was sick, she didn't have to take care of her newborn and toddler that she had. That was really incredible to see, everyone just kind of came together to support her.

By working together, Elaina and her colleagues were able to support a coworker for months—a feat that would otherwise be difficult for a sole individual. Importantly, this meal train recognized that Elaina’s coworker was both a healthcare worker and a mother with children who needed support too. Here, providing food is not only a practical gesture; it also recognizes that people can experience pain in their personal lives and that these issues may impact them both inside and outside of the workplace.

In another example, an EMT named William described how his coworkers reacted to the sudden loss of a colleague. Once again, people used food to support someone in
suffering:

So when she passed away, everybody really came together. Made meals for her family, we had a walk to raise money, stuff like that. It was good to see we were still capable of that even through COVID. That was August, which was one of our worst months. It was good to see that we were still able to do stuff like that even in one of our worst months.

William’s story showcases how food was a comfort to both the givers and receivers in this scenario. Despite the obvious tragedy that sparked this experience, William felt positive about his workplace afterwards because he witnessed his coworkers’ commitment to an unpaid multi-month effort all in the name of supporting one colleague. William also commented that “it didn’t feel artificial” at all because “it was not put on by higher ups who didn’t even know the nurses. It was especially from the people who worked closely with her.” Without financial incentives and management involved in this process, it was evident that workers were deliberately looking for opportunities to demonstrate compassion.

**Donating PTO or ETO**

Several participants mentioned that their organizations have a system that allows coworkers to donate paid time off (PTO) or earned time off (ETO) to whomever they choose. As Audrey, a 27-year-old registered nurse, explained: “You can donate ETO, which is earned time off. You can donate your off time and you can donate it to different people.” Although donating PTO or ETO can technically be done at the individual level, most participants described this action as a collective effort. This may be because the effects of PTO donations are only memorable or felt when a certain amount of hours
accumulates for the person in need. For example, Audrey shared how her coworkers pooled their ETO together for a coworker who had lost his entire home in a fire. Audrey and her coworkers also supplemented the ETO with gift cards and cash donations to help their coworker purchase new belongings.

In another example, Helen and her fellow pharmacists donated their PTO to one of their technicians. Helen explained that this compassionate action was initiated when Helen learned that her coworker would not receive a $1,000 bonus due to a technical error in accounting. Recognizing that her coworker was “a single mom with two kids…who depended on that paycheck,” Helen and her peers looked into possible solutions and resources. After investigating several options at her organization, Helen explained:

We found out that employees can gift her from their PTO. So if we can give her an hour or two, whatever, you can give this technician a PTO. So we planned to give her maybe an hour of each. Of course, nobody's going to give a thousand dollars all of sudden, but at least, an hour or two from the three of us…we could give it to her.

Although each worker in Helen’s example could only donate one or two hours, their collective efforts resulted in a sizeable amount of PTO for Helen’s coworker. Helen also noted that donating PTO was something only she and her fellow pharmacists or managers could practically achieve. Although technically the organizational policy allows anyone to donate, Helen realized that employees in entry-level positions who make less pay may not have been able to afford a donation. While Helen and her coworker’s efforts to pool their PTO is certainly an agentic act, it also (re)produces a problematic structure in
healthcare. By creating policies that allow for PTO/ETO donations, healthcare
organizations place the impetus for compassionate action on healthcare workers rather
than (re)evaluate their structure of overwhelming workload. PTO does not necessarily
need to be a rare resource if organizational structures and policies protect employee
leaves, benefits, and mental health days.

Creating Informal Committees

Although organizations sometimes provide opportunities to (re)act to others’ pain
through formal structures (e.g., access to mental health resources, policies that allow
PTO/ETO donation), many participants felt that they could better organize and coordinate
compassion outside of their organization’s jurisdiction. At times, participants created
informal committees to achieve a shared goal. Shelby, a 30-year-old registered nurse,
described how an informal committee formed in response to a coworker who was
diagnosed with cancer:

We had a bracelet, like those plastic jelly bracelet bands that everybody had for a
long time. We had those made for her and sold them and then had a link where
everybody bought her food and we've donated that to help her with her medical
costs and things like that…There were a couple girls that just kind of took charge.
One of them kind of took over the food drive part of it, and the other one got the
bracelet organized and went around unit to unit selling those.

As mentioned at the end of this exemplar, Shelby’s informal committee eventually
announced their efforts to management and received permission to solicit donations in the
workplace, which increased the visibility of their campaign.

In most cases, informal committees’ main challenge was responding to a
coworker’s crisis quickly and effectively. However, compassionate actions can also be proactive (Way & Tracy, 2012), as evidenced by the informal committee in Elaina’s organization. Wanting to prepare for potential crises, Elaina and her coworkers regularly contributed to a “sunshine fund” for emergencies. The committee in Elaina’s organization recognized the inevitability of pain and stress that can occur both outside and inside the workplace. Even when there were no immediately visible crises, this committee proactively collected funds so they could offer “extra love” and compassion to coworkers in need.

**Limiting Spiral Time**

Finally, participants discussed providing and gatekeeping “spiral time,” a discursive space where coworkers could vent to each other about various stressors in their day. The term “spiral” is taken from an interview with Samantha, a 31-year-old inpatient psychotherapist:

> We call them spirals. We tell each other, “You get two spirals a day, and that's it.” We jokingly tell people to “get off of their spiral, because you're spiraling too much, and you need to get off of that one.” And so that's just what we tell each other. And like, “You've already had a spiral today or you've had one big one, so that's it for you.” It brings us back down to earth a little bit and tries to redirect to “What's important here?” I know you're mad. I know you're frustrated, and that's how it's going to be for right now. But what's important?

Spiral time was not a formalized policy in Samantha’s organization, yet Samantha and her workers felt bound to the normative collective expectation nonetheless. Spiral time could be characterized as simultaneously enabling and constraining compassion among
coworkers. From one perspective, spiral time breaks the norm of emotional suppression in healthcare, allowing workers to verbalize their sufferings to others. On the other hand, spiral time is inherently a limiting space in the sense that workers are allowed only a brief amount of time or number of spirals per day.

Struck by the dynamic nature of spiral time, I began to ask interviewees if they had heard of or participated in any similar communicative phenomenon. Although the name “spiral time” was unique to Samantha’s workplace, other participants confirmed that their coworkers simultaneously invited and monitored emotional disclosures. Cecilia, a 34-year-old physician assistant, described how spiral time functioned in her experience:

I mean like, "Okay, you can vent for two minutes and then we got to go." Or like, "let me just vent for a second and then turn it off." Definitely heard stuff like that before...but it costs me later. If something was rough or hard, it will come up when I don't expect it. So I can definitely turn it off or compartmentalize or whatever you want to call it to get through the shift, right? But then on a day off or maybe at night or when you have the space or it's safe because people aren't depending on you then, then you feel it.

In Cecilia’s example, it is evident that spiral time is essentially a stopgap for stress—a temporary way to relieve stress during the workday, but not a long-term solution by any means. Cecilia invokes the norm of emotional suppression here as well, which is likely a major factor in why spiral time is presented as a limited-time opportunity where “safety” may not be guaranteed. By this logic, spiral time may function as a stress valve, releasing just enough pressure to allow healthcare workers to survive busy and difficult days at work.
Modeling Compassion

When healthcare workers (re)act compassionately at the individual or collective level, their actions carry implications for how compassion is understood and perceived in the workplace. Indeed, organizational compassion is only possible when compassion is legitimated, propagated, and coordinated by organizational members (Frost et al., 2006). Qualitative data revealed that participants looked for role models of compassion in their workplace and often changed their behavior to match them, thereby leading to a compassion contagion in the workplace.

Identifying Role Models of Compassion

Participants looked for role models of compassion all throughout their workplace, but they were especially aware of supervisors who modeled and endorsed compassion. Ariel, a 32-year-old case manager, expressed gratitude for compassionate team members and credited her supervisors for it:

I think that's because our boss and the providers show that. I think if they didn't show that, I think my coworkers would not be compassionate as often, if you're not modeled that. I think we're just naturally compassionate, at least my team. All of them are naturally, genuinely worried about anybody. I think it would be masked a little bit more if we didn't have that role model, just because we would be like, okay, I guess I got to be harder on everybody else.

Ariel notes that her coworkers sometimes feel the need to mask their compassion and empathy for others, conforming to the paradigm of rationality in healthcare (Dutta, 2008). Ariel’s observation coincides with prior research that highlights the transformative power of highly compassionate leaders (Tietsort, 2021). Most participants could name a specific
person in their organization who modeled compassion for others, listing many reasons why that person embodies compassion. Theodore, for example, shared:

I'd say one of our doctors is an exceptional role model for compassion. She will come in early if need be to meet with members if they're unable to come in during regularly scheduled business hours, stay late if she needs to, offer assistance with the team. She's willing to listen to any case manager from any team that will come speak with her for an issue to help brainstorm what needs to be done for the member to help them. She's always patient, never gets agitated or irritable. She has a great demeanor and really shows a lot of compassion for all the team members and the patients as well.

Importantly, Theodore’s description highlights the communicative nature of compassion. Theodore’s role model demonstrates specific behaviors in helping, listening, and speaking with employees. Employees take notice of their leaders’ behaviors, which can reduce uncertainty and cultivate spaces for safe disclosures (Tietsort, 2021).

**Observing and Mimicking Compassion in Others**

Once participants have identified role models of compassion in their workplace, they often begin closely observing and mimicking the behaviors they admire in others. Lucas, a resident physician, was particularly motivated in this regard. He explained:

So because the residency recruits compassionate individuals and takes time to recruit those individuals who kind of match that mindset, you're surrounded by that and you're enhanced by it…. I try and keep my eyes open to a lot of it and just like not necessarily be like a chameleon, but….I try and make myself very aware of other people's successes so that I can mimic or steal or copy from them
Lucas’ face lit up during the interview as he named three different role models in his organization, and he described in detail how he learned to be a better physician by following their example. Lucas also shared that he had just become a chief resident in his hospital and wanted to model compassion for his peers and subordinates too. For example, Lucas explained that while he typically prefers to keep his struggles private, he intentionally chose to share his experiences and emotions during “sharing circles” with his colleagues because he “thought it was a good exercise and wanted everybody to [be] involved in it.” Lucas’ story illuminates the potentially recursive nature of the compassion process and how one role model might begin a chain reaction of compassion.

**Practicing Self-compassion**

Some participants identified a difference between compassion for others and compassion for the self. Furthermore, some participants argued that self-compassion is the most neglected form of compassion in healthcare, and that it is often in tension with compassion for others. Phoebe, a 27-year-old physical therapist, explained the importance of self-compassion during tough days at work:

> It can be very draining to take on other people's things or what they have going on, and you have to have the things that make you feel better. Everybody always uses the analogy of when you're on a plane, if the oxygen mask drops, you have to get your own oxygen mask on before you can help somebody else. You can only actually help others if you're helping yourself too. So I think it's really important that we all take a step back and take the time to say, what fuels me, what makes me feel better so that I can go out and use my energy to help other people feel
From Phoebe’s perspective, self-compassion was not only about protecting herself; it was also about ensuring that patients receive care from her best self. By this logic, practicing self-compassion might be considered a prerequisite for other-centered compassion. However, structures and normative practices in healthcare often constrain the agency to engage in self-compassion. Such structures include overwhelming workload, disconnected decision-makers, and limited access to material resources (namely, staffing). When productivity is privileged over all other concerns, it is easy for organizational decision-makers to dismiss or minimize the importance of healthcare worker wellbeing. Cecilia, a physician assistant, reflected on how these structures in healthcare also perpetuate the practice of sharing workload:

> It's kind of taking advantage of the helper mentality of people that went into healthcare. And so the phrase isn't like, "Hey, we're understaffed and we're not paying somebody else to be there." It's "Hey, can you help out?" And of course that triggers that, "Of course I want to help out."

Cecilia continued to describe a case where an overwhelmed coworker asked if anyone could take their shift. Struggling themselves, Cecilia said that she and her coworkers refused to take on the additional load. Sharing workloads can be compassionate towards others at the cost of one’s own wellbeing, depending on whether the giver has the emotional and cognitive capacities to take on additional work. Instead, Cecilia offered a verbal acknowledgment of his stress: “We've all literally been in the same place that you're in right now. You'll get through it.” Cecilia’s act of self-compassion broke expectations to help her coworker, but Cecilia believed that boundary-setting would
enable her to stay in the healthcare industry longer. Although compassion is typically conceptualized as an other-oriented process, Phoebe and Cecilia’s stories highlight the importance of examining the giver’s emotional wellbeing.

**The Recursive Relationship between Structure and Agency in Compassion**

Structure and agency are intimately linked in a recursive relationship. The duality of structure is such that “structure is both the medium and the outcome of the human activities which it recursively organizes” (Giddens, 1986, p. 533). Actions (i.e., agency) produce and reproduce structure, and structure both enables and constrains the actions of organizational members. By applying a lens of structuration theory to compassion in healthcare organizations, the present study illuminates (a) how certain structures enable and/or constrain recognizing, relating, and (re)acting to suffering in others and (b) how healthcare workers (re)produce and/or transform the structures that guide their social interactions and displays of compassion toward one another. Compassionate interactions are constituted in organizations with structures that have varying implications about which emotions are socially appropriate and acceptable at work, and healthcare workers’ actions can reinforce or transform these expectations.

Figure 2 provides a specific example of the structuration of (non)compassion that can occur in healthcare settings. First, it is important to note that this model is not necessarily linear, and it makes no claim on which unit of social analysis (i.e., structure or agency) is “first” or more influential in this relationship. After all, the duality of structure in structuration theory intentionally moves away from dualism and does not position structure or agency in a dichotomous relationship (Giddens, 1987). Drawing upon the data of this study, the example featured in Figure 2 focuses on workloads in
healthcare organizations, but other structures could be applied to this model as well.

Figure 2

*Structuration of (Non)compassion in Healthcare*

In this case, a structure of domination in healthcare organizations is the overwhelming workload, which is both a common source of stress and a barrier towards recognizing suffering in fellow healthcare workers. Despite the challenges that the (re)production of this structure presents, many participants found ways to survive their overwhelming workloads and engage in agentic restructuring by sharing their workloads. Sharing workloads was one of the primary ways that participants engaged in the compassion process. Healthcare workers shared their workloads to relieve their peers’ burdens, often with the hope or expectation that their actions would someday be repaid.

As the findings of this study indicate, healthcare workers are observant of their
peers’ actions. Healthcare workers monitor each other’s actions and may even openly address or correct their coworkers’ behaviors (e.g., limiting spiral time). Just as healthcare workers can disapprove of certain behaviors, they can also endorse actions or model it themselves. Through social interactions, healthcare workers may perceive that their coworkers and/or managers endorse their actions. The data of this study suggests that healthcare workers often perceive endorsement regarding their decision to share workloads. For example, coworkers reproduce sharing workloads and ask for favors from one another, and managers may commend healthcare workers when tasks are accomplished. The dotted line in Figure 2 represents the possibility that perceptions of endorsement may not exist in every case and for every healthcare worker. Additionally, the dotted line represents cases where a healthcare worker may receive endorsement from some parties and not others (e.g., one coworker may be willing to share workloads, but another coworker may refuse to share workloads when practicing self-compassion).

When healthcare workers perceive that their actions are endorsed by others (especially organizational leaders), their actions are more likely to become routinized (Giddens, 1990). Healthcare workers in this study viewed sharing workloads as a sufficient way to survive the structure of overwhelming workloads, and as such they reproduced a structure that often constrains the compassion process. Over time, as structures are produced and reproduced, the rules for organizational life are carried in the “practical consciousness” of employees, whereby employees tacitly know the expectations of behavior in daily life without ever articulating them (Giddens, 1984). However, the existence of workers’ agency also presents an opportunity for change and transformation. For healthcare organizations, where many structures present barriers to
compassion, it will likely take time and effort to examine and transform existing structures. In the following chapter, the theoretical and practical implications of this study are discussed.
CHAPTER 4

DISCUSSION

Using a lens of structuration theory (Giddens, 1984), this dissertation examined compassion among healthcare workers. Two research questions were posed to identify: (a) the structures that healthcare workers describe as enabling and/or constraining compassion in the workplace and (b) the agentic ways that healthcare workers (re)produce or transform structures that affect compassion in their organizations. A phronetic iterative analysis of interview data revealed that various structures enabled and/or constrained compassion (e.g., healthcare norm of emotional suppression, alone-together workspaces, occupational challenges, the business model of healthcare, disconnected decision-makers, occupational norms of appreciation, access to therapy and mental health resources, and limited access to material resources). Healthcare workers also demonstrated individual agency (e.g., asking “how are you?” twice, sharing workload, embodying aboutness, and finding humor in pain) and collective agency (e.g., making and giving food, donating PTO or ETO, creating informal committees, and limiting spiral time) in engaging in the compassion process. In doing so, healthcare workers challenged or (re)produced the (non)compassionate structures that govern social interactions in the workplace.

Building on existing scholarship, this dissertation extends theorizing on compassion in four ways. First, this study delineates the differences between individual compassion, group compassion, and organizational compassion. Importantly, group-level compassion is an important bridge between individual and organizational compassion. Second, this study provides evidence of structurational divergence in healthcare
organizations, where incompatible structures regarding workload may be decreasing organizational compassion and increasing employee burnout. Third, this study reveals the potential limits and consequences of emphasizing compassion in healthcare, such as the difficulty of transforming structures and the feelings of obligation that healthcare workers may experience. Fourth, this study offers insight into why compassion programs and interventions may have varying degrees of success and sustainability, given the structures frequently (re)produced in healthcare organizations.

Following the theoretical contributions of this study, practical recommendations for augmenting compassion in healthcare organizations are provided. Recommendations include: (a) making structural changes related to scheduling, PTO, and benefits, (b) investing in a materiality of care, (c) creating space for healthcare workers’ voices, and (d) encouraging organizational leaders to model compassion and emotion-sharing.

**Theoretical Contributions**

**Individual Compassion vs. Group Compassion vs. Organizational Compassion**

Previously, compassion has been conceptualized as either an individual or organizational capacity (Kanov et al., 2004), but there has not been exploration of the group-level of compassion and its role in generating and sustaining compassion in the workplace. Group compassion can be meaningfully positioned as a bridge between individual and organizational compassion. This study delineates key differences between individual, group, and organizational compassion, described in more detail below.

At the individual level, compassion has been construed as an innate response to human suffering (Dutton et al., 2006) and a biological predisposition toward empathy and concern for others (Hou et al., 2017). Prior research has also indicated that demographic
characteristics and personality traits predict differences in displays of compassion (Dutton et al., 2014). A small number of participants in this study supported this conceptualization of compassion, claiming that their compassion towards others could be tied to identity traits of gender or extroversion. However, most participants described compassion as effortful work drawing upon cognitive, affective, and communicative skills (Kanov et al., 2004; Miller, 2007). These skills are necessary to engage in the compassion process and effectively recognize, relate, and (re)act to suffering in others (Way & Tracy, 2012).

In the healthcare context, the effortful nature of compassion is particularly pronounced. The findings of this study demonstrate that the compassion process is sometimes halted at its inception, with many participants unable or refusing to recognize suffering in their coworkers. From a perspective of individual compassion, this finding could be explained as co-workers simply choosing not to engage in an effortful, extra-role behavior. Nurses, who are already expected to demonstrate care towards patients (Apker et al., 2005; Dean et al., 2016), may be especially resistant to an additional expectation of demonstrating compassion to coworkers too. Indeed, prior research has shown that healthcare organizations rarely incentivize or reward compassionate acts to coworkers (McClelland & Vogus, 2014). Some healthcare workers also fear situations requiring empathy, viewing the emotional work as a “Pandora’s box” that would be difficult to control (Hardee & Platt, 2010). Yet the data of this study also reveals that many participants willingly engaged in the compassion process by asking “how are you?” twice, sharing workloads, embodying aboutness, and finding humor in pain. Through the frame of past literature theorizing individual compassion (Kanov et al., 2004), the
visibility of compassion in an organization could be described as a matter of preference among healthcare workers; perhaps some employees see intrinsic value in acting compassionately in their workplace and others do not. It is also possible that some individuals may be constrained by structures while others are not (e.g., night-shift workers and day-shift workers). Psychologists adhering to a trait view of compassion might also argue that some employees are inherently compassionate while other employees are not (Hou et al., 2017).

At the group level, compassion manifests through collective agency in situations where three or more people coordinate to recognize, relate, and (re)act to a coworker in suffering. More specifically, compassion at the group level involves a co-constructed process where multiple people can dynamically affect how a problem is interpreted, how empathy is generated, and how (re)actions are formed. Participants in this study described ways they collectively engaged in compassion by: making and giving food, donating PTO or ETO, creating informal committees, and limiting spiral time. Although these actions can technically be performed at the individual level, participants described these actions as (a) more achievable when the effort of compassion was executed by a group, and (b) more memorable due to the accumulation of time and effort spent to support a coworker. When suffering is recognized at work, it is highly likely that a person may choose to reflect upon the situation and coordinate actions with others. For compassion to occur at the individual level, one person must be able to recognize, relate, and (re)act to suffering in another person (Way & Tracy, 2012). In other words, one person carries the labor of (a) interpreting the nonverbal and verbal cues of distress in another (i.e., recognizing), (b) identifying with and connecting to the emotional pain of another (i.e.,
relating), and (c) acting in ways that could be seen as compassionate (i.e., (re)acting). The subprocesses of compassion require a significant amount of information (about situational context, cues, options for responding, etc.) to be processed and critically applied.

Practically, group compassion means that the labor of compassion can be shared among many. For example, in this study, healthcare workers organized a meal train for a coworker with cancer. This effort would have required, at minimum: (a) information-sharing to increase the recognition of a coworker’s issue, (b) collective reflecting on an emotionally charged topic, (c) debating potential actions that could alleviate the pain, and (d) coordinating and executing a specific plan of compassion over an extended period. Participants in this study largely described group compassion as a co-constructed process where each subprocess of compassion benefitted from a multiplicity of voices. However, it is also possible that group compassion creates the opportunity for specialization among coworkers. For example, healthcare workers might share the labor of compassion by focusing individual efforts on one subprocess (i.e., recognizing, relating, or (re)acting) with the understanding that a peer would fulfill another role.

By offering a group-level conceptualization of compassion, this study echoes prior scholarship in highlighting the interactional nature of compassion (Miller, 2007; Way & Tracy, 2012). Although compassion has previously been discussed as a form of dyadic, interpersonal work (Frost et al., 2006), this study highlights how group compassion carries implications about how compassion is learned and (re)produced among coworkers. Participants in this study regularly observed and mimicked the compassion they saw in others, which echoes prior research indicating that facial
mimicry generally sparks emotional contagion (Hatfield et al., 2014). In the research area of emotional contagion, it is still unclear what social and contextual factors shape emotional contagion (Hatfield et al., 2014), but the findings of this study indicate that some participants were especially motivated to identify role models of compassion among their organizational leaders and mimic them. In sum, when healthcare workers engage in compassion as a collective, they socially promote compassion and influence future interpretations of what it means to be compassionate in the workplace. Group compassion creates pathways toward organizational compassion.

At the organizational level, compassion has been described as collectively engaging in the steps of the compassion process (Dutton et al., 2006; Kanov et al., 2004). This study proposes that through a communication lens organizational compassion should be defined as: the collective capacity to recognize, relate, and (re)act to suffering in the organization, which is enabled and/or constrained by organizational structures. Scholars have theorized that compassion becomes an organizational capacity when the subprocesses of compassion are legitimated, propagated, and coordinated by organizational members (Frost et al., 2006; Kanov et al., 2004). This study provides empirical support of this claim, and additionally highlights how organizational compassion is co-constructed, communicative, and collaborative.

As an organizational capacity, healthcare workers’ compassion can be explained as both an individual and/or group skill set and a collective process grounded in organizational structures. Scholars gain greater nuance in investigations of compassion when they consider the ways that norms, rules, and resources influence displays of compassion at work. For example, although a healthcare worker’s decision to share their
emotions with a coworker is indeed a personal choice, it is also likely influenced by the healthcare norm of emotional suppression. Structures create formal and informal routines in organizational life, and those routines provide a sense of familiarity and psychological comfort for employees (Giddens, 1990). As such, many healthcare workers may find it difficult to act in non-normative ways. After all, the relational and emotional nature of compassion is seemingly at odds with the dominant biomedical approach to healthcare, which favors rationality and efficiency (Bisel & Zanin, 2016; Dutta, 2008). Accepting the status quo of an organization is also the path of least resistance.

Despite the lack of structural support for compassion in healthcare, workers’ participation in group compassion and awareness of their peers’ actions suggest that structures of compassion could be fostered through agentic action. The findings of this study provide evidence that healthcare workers strategically challenge structures that constrain compassion in their organization at both the individual and group level. For example, although participants indicated that emotion-sharing might be considered unprofessional, they also described the ways they created space for difficult emotions by asking “how are you” twice and collectively engaging in spiral times. Healthcare workers can validate or invalidate each other’s compassionate practices, thereby transforming or (re)producing structures of compassion through social interactions. If healthcare stakeholders want to nurture organizational compassion, it is important to attend to the ways in which existing structures constrain compassion and commit to transforming such structures. Additionally, healthcare stakeholders must attend to divergent structures in healthcare that may communicate mixed messages about the value and practice of compassion in the workplace.
Structurational Divergence in Healthcare

Healthcare organizations are rife with potential for structurational divergence (Nicotera, 2015; Nicotera et al., 2010). As a reminder, structurational divergence is a phenomenon that occurs when incompatible structures operate simultaneously and appear equally obligatory (i.e., an SD nexus), which may result in workers’ experiencing a downward spiral of communication known as an SD cycle. The SD cycle is marked by unresolved conflict, immobilization, and inability to develop and achieve goals (Nicotera, 2015). The data of this study echoes prior research on structurational divergence in healthcare, and it also draws attention to another SD nexus that healthcare workers experienced in relation to their workloads. Nurses’ workloads have previously been examined from a lens of structurational divergence, but this research has typically focused on incompatible structures that portray nursing work as task-oriented or relational-oriented (Nicotera et al., 2010). Related, nurses may feel caught between the administrative and patient-centered aspects of their work (Anderson, 2015). This tension between task and relationship is also seen in the present study, as evidenced by participants who felt that the business model of healthcare is incompatible with patient-centered care.

However, the findings of this study also indicate that there is another SD nexus occurring in relation to how healthcare workers are expected to manage their workloads. When structures of overwhelming workloads are paired with a norm of emotional suppression, healthcare workers feel obligated to complete their many tasks alone without displaying emotional distress or asking for help from coworkers. Despite structures that encourage emotional stoicism and performing tasks alone, healthcare workers also feel
obligated to ask their coworkers if they need help, creating situations where an individual must manage even more work. Managers and administrators reinforce the altruistic identities of healthcare workers (Real et al., 2009), which encourages employees to find ways to survive their workloads among themselves rather than in seeking structural changes. Some policies in healthcare organizations (e.g., PTO/ETO donation policies) also suggest that it is normal for healthcare workers to take on additional labor and make personal sacrifices in support of a coworker. If healthcare workers reject coworkers’ pleas for assistance, it may result in conflict. Altogether, healthcare workers are expected to simultaneously: (a) protect their emotional wellbeing (i.e., access mental health resources and practice self-care), (b) manage their overwhelming workloads efficiently, and (c) remain emotionally stoic.

Simply put, structures in healthcare communicate conflicting messages about whether one’s workload should be managed independently or interdependently. This tension carries important implications for compassion among healthcare workers. Scholars have previously theorized that organizational compassion may be more likely to manifest in the context of interdependent relationships, presumably because interdependence creates a relational history that would compel workers to care for one another (Madden et al., 2012). This study provides empirical support for the notion that interdependence is linked with organizational compassion, given that participants were more likely to receive and give compassion to their immediate coworkers with whom they shared job responsibilities. The link between interdependence and organizational compassion also offers a potential explanation for disconnected decision-makers in healthcare; upper management may struggle to recognize, relate, and (re)act to workers’
pain because their relationship is not necessarily interdependent, which is why several participants called for managers to participate in job-shadowing.

Whereas an interdependent expectation to work suggests that task coordination and collaboration is welcome, an independent expectation to work provides little to no opportunity for soliciting help and recognizing pain in others. When structures in healthcare present independence and interdependence as equally viable yet contradictory approaches to work, healthcare workers may feel immobilized and struggle to identify which emotions and behaviors are appropriate for their workplace. Healthcare workers’ use of “spiral time” (i.e., putting restrictions on coworkers’ emotional venting) is likely an attempt to appeal to incompatible structures by simultaneously creating a space to collectively recognize pain and limiting the number of disclosures to maintain a sense of professionalism and independence. Spiral time is an excellent example of creative, agentic action in the face of constraining structures. In one sense, by making emotional expression possible, spiral time might de-escalate the SD cycle. However, it is also possible that rigid adherence to spiral time rules could escalate the SD nexus into an SD cycle. Considering such possibilities, it is no surprise that navigating structural divergence is an exhausting effort that may place employees on an accelerated path to burnout (Nicotera & Mahon, 2013). Therefore, healthcare stakeholders should strive to identify and reconcile incompatible structures within the organization.

Limits and (Un)intended Consequences of Compassion in Healthcare

The findings of this study demonstrate the transformative power of compassion in healthcare. Although most participants admitted to feelings of exhaustion and disengagement, participants also consistently described evidence of compassion as a
source of solace and a reason to stay within the healthcare industry. Through compassion, organizations can become sites of healing, comfort, and human connection (Dutton & Workman, 2011). However, it is also important to acknowledge that compassion is not a panacea. Scholars have argued that the “heart” of the compassion process is (re)acting to suffering (Way & Tracy, 2012, p. 308), which is not to be confused with eliminating suffering altogether. Pain and difficult emotions are inevitable in any organization (Frost, 1999), but structures that enable compassion would equip healthcare workers to better recognize, relate, and (re)act to suffering as both individuals and collectives.

Any organization is technically capable of fostering compassion and virtuousness (Cameron et al., 2003). From a lens of structuration theory, this would first require a close examination of the rules and resources (i.e., structures) that enable and/or constrain the compassion process. Then, organizational stakeholders would likely need to: (a) augment structures that support compassion, (b) transform structures that inhibit compassion, and (c) reduce uncertainty around divergent structures. Such efforts would necessitate agentic actions from employees, given that agency is the means by which structure is (re)produced or transformed (Giddens, 1984).

As one might imagine, however, changing organizational structures can be a slow process. Structures are not immovable, but historically sedimented structures such as the ones commonly seen in healthcare organizations may be rigid in the face of change. For example, several of the structures identified in this study (i.e., overwhelming workloads, limited staffing, disconnected decision-makers, and the business model of healthcare) are arguably borne from a managed care model of healthcare. The managed care model is an approach to healthcare that emphasizes cost reduction and efficiency, and it also
privileges manager perspectives over healthcare worker perspectives (Ray & Apker, 2010). Managed care has been associated with the rise of health maintenance organizations and insurance-driven healthcare since the early 1970s (Harrill & Melon, 2021), and it continues to guide the operations and financial decisions of many healthcare organizations today through deeply embedded structures.

Beyond the managed care model of healthcare, the structures described in this study can also be linked to broader societal structures that pervade contemporary organizing in general. The features of a managed care model are ultimately instantiations of bureaucratic organizational structures. Bureaucracy is arguably one of the most pervasive organizational forms in Western society, which is why many organizations continue to privilege formal hierarchies, rigid structures, and standardized policies (Ashcraft, 2006). Furthermore, bureaucracy itself is tied to the economic structure of capitalism. For-profit and non-profit organizations alike are impacted by the market-based and gain/loss logics of capitalism (Kuhn, 2017). Healthcare organizations must stay financially solvent to survive competitive markets. In short, many of the structures described in this study are reflective of the suprasystems in which healthcare organizations are housed, and those enduring relationships may make organizational change more challenging. The challenge of organizational change is also compounded by the fact that healthcare workers often (re)produce the existing structures that exploit them and dismiss compassion.

In addition to being challenging, the pursuit of organizational compassion comes with certain risks. First, some organizational stakeholders strategically perform compassion, creating “compassionate” policies for the purposes of plausible deniability
and bolstering public image (Simpson et al., 2014). As evidenced by this dissertation, healthcare workers are observant of the ways in which managers and administrators demonstrate compassion or the lack thereof. When healthcare workers perceive gestures from management as insincere or shallow attempts at compassion (e.g., providing decorative pins rather than food), a boomerang effect can occur where feelings of resentment and disconnect build instead. Second, structures of compassion may create a sense of obligation around compassion. Most participants in this study found interesting and creative ways to engage in the compassion process, often with the hope that their deeds would be repaid if they required help in the future. However, some participants expressed dissatisfaction or guilt when their coworkers expected help from them. Again, the effortful nature of the compassion process (requiring mental, emotional, and communicative work) should not be underestimated, especially considering the demanding and emotionally taxing workloads that monopolize healthcare workers’ energy and time. Healthcare workers may feel that compassion for others comes at the cost of self-care, so healthcare stakeholders must be cautious about messaging around healthy boundary-setting and self-care practices. This study has shown that a common weakness in healthcare organizations is mixed messaging about the availability and desirability of mental health resources.

**Compassion Programs and Interventions**

Attempts to foster compassion in the workplace sometimes come in the form of formal programs and interventions. Two notable examples introduced in the literature review of this dissertation: the “Cultivating Compassion Project” (Curtis et al., 2017) and the “Leading with Compassion Recognition Scheme” (Hewison et al., 2018), sharing the
common goal of generating employee awareness of compassion in the workplace. However, they executed their vision in different ways. The “Cultivating Compassion Project” focused on increasing employees’ competency and interest in compassion through monthly training. In contrast, the “Leading with Compassion Recognition Scheme” focused more on identifying role models of compassion and rewarding compassionate acts. The findings of this dissertation offer potential explanatory mechanisms for the varying degrees of success in compassion programs of prior research.

The aforementioned compassion programs are commendable for addressing a specific need within healthcare organizations. Given that emotional displays and compassionate organizing are often muted by healthcare structures, organizational stakeholders need to find ways to socially sanction and publicize the compassion process. By prioritizing employees’ “awareness” of compassion, these programs indirectly suggest that compassion is contagious. This study also shows evidence of compassion contagion, as indicated by healthcare workers’ tendencies to look for compassion role models in their organization and mimic their behaviors. However, an emphasis on compassion awareness alone places the burden of responsibility upon the individual, and it does not speak to the potential for structural change. Unsurprisingly, these programs noted that many employees expressed skepticism and resistance. Employee skepticism could be the result of a variety of factors, including but not limited to a lack of trust in management’s intentions, perceptions of structurational divergence, and concerns that a compassion program is only a cosmetic change (e.g., an aesthetic pin does not actually address healthcare workers’ needs). Skepticism towards any type of organizational change is also
a relatively expected response, given that employees generally feel more comfortable with the status quo (Giddens, 1987).

Perhaps the more important question here is: does employee skepticism indicate that a compassion program or intervention is ineffective? Of course, this is a question that merits exploration at each organization because compassion programs can be radically different in their purpose, design, and outcomes. However, a structurational approach to organizational compassion offers some broad insights into what makes a compassion program successful and sustainable. First, as discussed it is important to note that healthcare structures are not likely to change quickly. Organizational change may be especially slow in cases of structurational divergence, which can immobilize healthcare workers and limit their agency (Nicotera, 2015). The findings of this study show that most healthcare workers engage in the compassion process in relatively subtle ways, mindful of the ways that their actions could be seen as threatening or unprofessional to others. For example, asking “how are you” twice is a display of agency that challenges the norm of emotional suppression in healthcare, but it is relatively unobtrusive in casual conversation. As previous scholars have suggested, however, “small moves” of compassion do not necessarily translate to a small impact (Frost et al., 2006, p. 18). Small acts of compassion may be remembered and (re)produced by other organizational members. Indeed, asking “how are you” twice is an example of what I am calling earnest script-breaking, where an employee recognizes the scriptedness of social interaction, disrupts routine with intentional verbal and/or nonverbal communication, and creates space for genuine conversation and emotion-sharing. As more healthcare workers engage
in earnest script-breaking, there may be more space to implement a compassion intervention and/or transform existing structures.

A compassion intervention targeted at the individual level may be more likely to yield quickly testable results. For example, a workshop that trains healthcare workers to develop specific skill sets or engage in earnest script-breaking could be implemented and tested with relative ease. However, training an individual in compassion places the burden of responsibility solely onto the individual, and it does not necessarily guarantee that the individual would exercise that skill set in the workplace. In this regard, group and organizational compassion may be more likely to create a precedent for future compassion in the workplace. The coordination and collaboration necessary for groups to act compassionately provides an excellent stage for the compassion process. When participants provided examples of collective compassion, many also described a sense of confidence that their coworkers could achieve similar feats again.

**Practical Contributions**

Given there are many ways to (re)act compassionately to someone in suffering, there are also many ways that healthcare stakeholders can generate and infuse the compassion process into organizational life. The findings of this study indicate four practical pathways for cultivating compassion among healthcare workers: (a) making structural changes related to scheduling, PTO, and benefits, (b) investing in a materiality of care, (c) creating space for healthcare worker feedback, and (d) encouraging organizational leaders to model compassion and emotion-sharing.
Making Structural Changes Related to Scheduling, PTO, and Benefits

First, healthcare stakeholders should pursue structural changes related to scheduling, PTO/ETO, and benefits (e.g., therapy and other mental health support). Almost all participants in this study identified themselves as burnt out or rapidly approaching a state of burnout. Healthcare workers face a variety of intense job demands, some of which can be attributed to the nature of healthcare work itself and some that are borne from unreasonably high expectations. For example, healthcare work is demanding in the sense that it is highly technical and emotional (Carayon et al., 2019); healthcare workers must retain and apply specific medical knowledge, and they must also manage their emotions to effectively engage with patients. With the introduction of COVID-19, the stressors of healthcare work reached new heights as healthcare workers were exposed to levels of death and pain their training could not anticipate.

Despite the challenging nature of their work, healthcare workers are often expected to maintain their focus and a high quality of care over long shifts. Longer shifts for healthcare workers ranged from 12 to 28 hours in this study, and often workers only have time to sleep at home before they need to head to their next shift. As it is, healthcare workers’ time and energy are monopolized by their schedules, leaving little chance for healthcare workers to build meaningful relationships and systems of support with coworkers. Healthcare workers would greatly benefit from shorter work hours or, at the very least, flexible scheduling where off days and PTO provide a reprieve between longer shifts. Just as a flexible schedule communicates the importance of rest, easy access to mental health resources would communicate care for healthcare workers’ wellbeing. By positively promoting mental health services for employees (ideally, at free or reduced
costs), healthcare organizations move away from norms of emotional suppression that stunt the compassion process.

In addition to protecting healthcare workers’ wellbeing, creating a supportive environment for healthcare workers is also a financially responsible goal. Given that burnout is highly predictive of turnover and job withdrawal (Maslach et al., 2001) and that turnover is a costly outcome (requiring additional hiring and training), it behooves healthcare leaders to create environments healthcare workers want to stay in. To accomplish such goals budgetarily, healthcare leaders may need to reevaluate which services and resources are more helpful than cosmetic. For example, some participants in this study appreciated the concept of a full-time wellness or fitness coach but could not practically utilize this resource due to their schedules. In such cases, it makes better fiscal sense to invest money into benefits that healthcare workers can readily use regardless of schedule constraints (e.g., access to a local gym, online counseling, etc.).

**Investing in a Materiality of Care**

Second, the findings of this study indicate the importance of investing in a materiality of care. Material resources can have a significant impact on healthcare workers’ experiences. Importantly, these material resources should be a clear response to healthcare workers’ needs and interests. Healthcare workers want to see tangible evidence that perspective-taking has occurred, and that management cares about their wellbeing. One way this can be achieved is through the provision of food. Although food may be less costly and permanent than decorative pins and customized t-shirts, food addresses a basic human need that can be easily forgotten or neglected in the chaotic day of a healthcare worker. Healthcare workers in this study were especially grateful for hot
meals, coffee, and desserts. Managers should strive to provide a range of food options for healthcare workers, with comparable options available for both dayshift and night-shift employees to avoid perceptions of favoritism. Additionally, an unexpected or surprise gift of food can be a proactive way to address suffering in healthcare workers and demonstrate appreciation for their continued efforts.

A materiality of care can also be achieved through the physical design of work environments. As evidenced by healthcare workers’ experiences with alone-together workspaces, simple design choices can influence feelings of comfort and connection when communicating with coworkers. Additionally, workers’ physical environments affected their likelihood of engaging in emotion-sharing conversations with coworkers. Although some participants highlighted the importance of privacy and personal space, most participants instead imagined the possibilities of an open floor plan where coworkers can easily converse and share space with one another. Relatedly, healthcare workers also discussed the importance of having comfortable seating arrangements where employees would be able to easily see one another. Healthcare stakeholders should critically evaluate what physical spaces exists within their workplace that could serve as spaces of connection and respite.

Additionally, having a dedicated breakroom for employees does not necessarily mean that the room has been arranged to its fullest potential. Healthcare stakeholders may find it helpful to conduct a survey of employees’ preferences regarding furniture for their breakroom, but this study provides a helpful starting point for designing such spaces. According to the data of this study, healthcare workers commonly desire open floor plans, comfortable chairs and couches, refrigerators, coffee machines, soft lighting, large
windows, and colorful walls. Prior research on interior design has also shown that neutral colors and neutral materials (cotton and wood) can be beneficial for mental health (López & Díaz, 2022).

**Creating Space for Healthcare Workers’ Feedback**

Third, healthcare workers need formal spaces and opportunities to share their concerns, both with their peers and with their managers. It can be easy to assume that the stressors in healthcare are relatively unchanging (e.g., the stress of intense job demands, high turnover rates, interpersonal conflict, etc.). However, the compassion process is not built on (re)acting to assumptions; it requires a thoughtful interpretation and understanding of another person’s suffering. Disconnected decision-makers in healthcare organizations often make assumptions about what healthcare workers want or need without understanding healthcare workers’ unique pain and suffering. To avoid this, decision-makers need to solicit healthcare workers’ specific feedback and demonstrate that their perspectives are valid and heard.

One way to create space for conversation is at the group level, possible sites being forums or meetings. On one hand, meetings are promising sites of organizational compassion because they allow healthcare leaders to model compassion publicly, invite emotion-sharing, and create space to collectively discuss difficult issues and emotions. On the other hand, meetings can be a difficult and intimating place to share feedback for many employees, especially in organizations marked by high levels of conflict and power disparity. Employees may be reluctant to voice any disagreement with their supervisors’ ideas, a phenomenon known as the hierarchical mum effect (Bisel et al., 2012). In cases such as these, formalized meetings must be structured in such a way that all parties are
expected to contribute to conversation (e.g., all meeting attendees must bring a problem and solution to meetings). Additionally, recognizing that employees require a feeling of safety when sharing their concerns (Detert & Burris, 2007), another route may be to collect feedback through anonymous feedback systems and act upon compiled findings. In particular, digitally-enabled, anonymous feedback has been linked with perceived positive organizational change and affective commitment to the organization (Kim & Leach, 2020).

**Encouraging Organizational Leaders to Model Compassion and Emotion-sharing**

Finally, leaders in healthcare organizations should be encouraged to model compassion and emotion-sharing. Overall, the findings of this study indicate that healthcare workers are highly cognizant of their coworkers’ behaviors, which generally feeds a recurring cycle of norms that mute emotional expression. However, healthcare workers’ awareness of one another can also be a promising pathway for modeling compassion and emotion-sharing. Anyone could spark this process but seeing an organizational leader (regardless of whether that leader is defined by social or legitimate power) openly endorse non-normative scripts and practices related to compassion would be especially memorable and inspiring for healthcare workers. Without formal training or knowledge of the compassion process, healthcare workers learn what it means to be compassionate in the workplace by observing key role models and replicating their behaviors. As such, organizational leaders can initiate emotion-sharing by disclosing their own feelings and demonstrate the communicative nature of compassion by actively listening, embodying aboutness, verbalizing empathy, and clearly responding to others’
pain. In turn, this can spark a cascade of compassion contagion where current leaders model compassion for the future leaders of healthcare organizations.

**Limitations**

Like all empirical studies, this study has limitations. First, in any qualitative study, researchers must recognize that they are the research instrument through which all data is collected and interpreted. Engaging in self-reflexivity is key to understanding how a scholar’s background (e.g., experiences, point of views, roles) influences understandings of a research context (Tracy, 2020). In the spirit of transparency and self-reflexivity, I described my unique position and personal ties to healthcare settings in the method of this study. As discussed previously, my position as an “outsider” with no formal ties to healthcare is beneficial because I can approach the research scene with curiosity and a unique standpoint that helps me recognize certain rules and structures that insiders may not see. However, this is not to say that I am without bias as a researcher.

I have taken steps to challenge my bias (e.g., self-reflexivity exercises during memo-writing, sensemaking with others, noting cases of disconfirmation in data and literature), and through these concurrent processes I have also recognized ways in which my body (i.e., ethnicity, age, gender) may inhibit data collection at times. My appearance as a young Asian-American female may have influenced participants’ decisions to share certain stories and information with me. Participants who identified as female and people of color may have felt more comfortable disclosing in interviews due to our perceived similarities, but participants who identified as male or were older in age may have been more selective in their responses. Additionally, although I worked to familiarize myself with the healthcare industry by studying prior research before data collection began, there
were times when I needed to ask participants to define healthcare jargon and shorthand during interviews. Again, my position as outsider allows for a unique perspective of organizational language, but such inquires might also influence or interrupt the flow of conversation during data collection.

Second, this study utilized a maximum variation sample to seek out a wide range of perspectives on compassion with a specific focus in healthcare. In this study, a maximum variation sample focused on diverse occupations provided the opportunity to identify structures that are common across many healthcare organizations. Although participants’ occupations and locations varied widely, many structures appeared consistently in the data, which reinforces the idea that healthcare organizations are also reflections of the suprasystems in which they reside and thus face similar challenges regarding compassion (e.g., biomedical and managed care model discourses). However, it would be an extreme oversimplification to say that all healthcare organizations are similar. Every healthcare organization has a unique culture with stories, norms, and artifacts that could reinforce or transform organizational structures related to compassion. Additionally, the nature of an organizational culture may create or limit space for healthcare workers’ agentic actions. Future research should investigate how healthcare organizations’ cultures influence the compassion process.

Third, this study was conducted during the global pandemic of COVID-19. As healthcare workers, participants were exposed to extremely difficult situations and higher rates of patient death than previous years (Morgantini et al., 2020). Although burnout is a historic issue in healthcare professions (Carayon et al., 2019), COVID-19 likely exacerbated feelings of stress, exhaustion, and disengagement. In the context of a global
pandemic, compassion is more urgently needed than ever. However, it should be noted that the pandemic may have influenced participants’ observations and interpretations of their organization, sensitizing them to certain issues that may or may not remain in their workplace post-pandemic. To address this possibility, the interview guide for this study contained multiple questions directly inquiring about changes that have emerged as a result of COVID-19. Participants were usually able to articulate differences in their organizations before and during the pandemic, but the possibility remains that COVID-19 influenced the type of stories shared.

Finally, this study’s sample is largely White and female. The sample is 66.67% White/Caucasian and 77.78% female. The nature of this sample may be linked to the use of snowball sampling, especially if participants were recommending colleagues who were demographically similar to them. As such, certain identities (e.g., racial minorities, men) are underrepresented in this sample. Future research should aim to diversify the voices represented in investigations of compassion, especially because “compassionate” policies may be used as a mode of power against marginalized groups (Simpson et al., 2014). It is unclear why mostly women responded to recruitment materials for this study, but prior research has shown that male participants can be difficult to recruit for studies related to delicate topics, especially if the content of interviews could lead to negative perceptions of participants (Tracy & Rivera, 2010). For this study, it is possible that potential male interviewees were cognizant of societal expectations about the appropriateness of emotion-sharing for men and women. Future research should consider the ways in which compassion might be a gendered expectation in healthcare settings.
**Future Directions**

Future research should extend and solidify understandings of organizational compassion in healthcare. First, observational and ethnographic approaches may be particularly helpful in investigating the structuration of the compassion process. Although self-report interview data is an excellent opportunity to analyze participants’ lived experiences, certain rules and resources may not be described in the space of interviews. Similarly, field research might provide additional insights on the individual and collective acts of agency that healthcare workers perform to support one another. Given that the compassion process is fundamentally tied to the communication and interpretation of verbal and nonverbal cues (Way & Tracy, 2012), observational data could focus on how healthcare workers embody aboutness and compassion (Huffman, 2017).

Second, future research could examine (non)compassionate policies in healthcare and how healthcare workers construct understandings of such policies. Participants in this study admitted that they lacked familiarity with many of their organizations’ policies and were unsure of the ways that policies could help or hinder their wellbeing and displays of compassion. Potentially, a lens of structurating activity theory (Canary, 2010) could be helpful in investigations of policy knowledge. Structurating activity theory draws attention to how policy knowledge is constructed and legitimized in the recursive space between structure and action. Prior research has demonstrated the utility of structurating activity theory in the analysis of system-level and structural-level contradictions in surgical work teams (Seamons & Canary, 2017). Structurational divergence as seen in this study may be an indicator of contradictions regarding workloads. By identifying
contradictions within policy, organizational stakeholders may be able to address and transform aspects of policy that do not serve the needs of employees (Canary, 2010).

Third, the findings of this study illuminate multiple areas that could be targeted through healthcare interventions. Programs of organizational compassion have had limited success in the past (e.g., Curtis et al., 2017; Hewison et al., 2018) due to a focus on improving compassion at the individual level. Interventions focused on fostering group and organizational compassion may lead to different outcomes, especially if structural change is made possible.

Although many types of interventions might be helpful in healthcare, this study indicates that an intervention focused on material resources that foster compassion is a promising future research direction. As indicated by the stories that participants shared, addressing healthcare workers’ needs through food and strategically designed rooms may increase the likelihood of compassion among healthcare workers. Toward this end, I have started to design a 2x2 experiment that would test how the presence of food and certain furniture items may impact healthcare workers’ likelihood to demonstrate compassion to others and provide emotional support to a colleague in suffering. A full description of such an experiment is beyond the scope of this study, but I offer a preview of this future research direction in Appendices F and G, which show images of different healthcare rooms (with high/low food and furniture conditions) and a corresponding survey to be distributed through Qualtrics.

**Conclusion**

Drawing upon on compassion scholarship (e.g., Frost et al., 2006; Kanov et al., 2004; Way & Tracy, 2012) and structuration theory (Giddens, 1984), this study examined
the structures that healthcare workers described as enabling and/or constraining compassion, and the ways that healthcare workers (re)produce and transform these structures. Healthcare workers described many structures that constrained recognizing, relating, and (re)acting to suffering, but they also found ways to engage in individual and collective action to support one another and sometimes challenge the status quo of compassion in their organizations. Notably, coordinated acts of compassion at the group-level revealed how compassion is co-constructed, communicative, and can be collaborative. In sum, compassion should be regarded not only as an individual skill set (Kanov et al., 2004) and interactional process (Way & Tracy, 2012), but also an organizational capacity grounded in structure and agency.
REFERENCES


Whitbred, R., Fonti, F., Steglich, C., & Contractor, N. (2011). From microactions to macrostructure and back: A structurational approach to the evolution of


APPENDIX A

IRB APPROVAL LETTER
EXEMPTION GRANTED

Alaina Zanin
CLAS-SS: Human Communication, Hugh Downs School of
(480) 965-5095
Alaina.Zanin@asu.edu

Dear Alaina Zanin:

On 10/4/2021 the ASU IRB reviewed the following protocol:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Combatting Burnout with Organizational Compassion in Healthcare Organizations: An Examination of Structural Barriers and Opportunities for Agency in Cultivating Compassion</td>
</tr>
</tbody>
</table>

Investigator: Alaina Zanin
IRB ID: STUDY00014658
Funding: Name: P.E.O. International
Grant Title:
Grant ID:
Documents Reviewed:
- Leach and Zanin IRB form_updated.docx, Category: IRB Protocol;
- PEO Scholar Award Letter.pdf, Category: Sponsor Attachment;
- Supporting document_Consent form in Qualtrics_04-10-21_update.pdf, Category: Consent Form;
- Supporting documents_Interview protocol_04-10-21 updated.pdf, Category: Measures (Survey questions/Interview questions/interview guides/focus group questions);

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 10/4/2021.
In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

If any changes are made to the study, the IRB must be notified at research.integrity@asu.edu to determine if additional reviews/approvals are required. Changes may include but not limited to revisions to data collection, survey and/or interview questions, and vulnerable populations, etc.

All in-person interactions with human subjects require the completion of the ASU Daily Health Check by the ASU members prior to the interaction and the use of face coverings by researchers, research teams and research participants during the interaction. These requirements will minimize risk, protect health and support a safe research environment. These requirements apply both on- and off-campus.

The above change is effective immediately until further notice and replaces all previously published guidance. Thank you for your continued commitment to ensuring a healthy and productive ASU community.

Sincerely,

IRB Administrator

cc:   Rebecca Leach
      Alaina Zanin
      Rebecca Leach
Hello [insert participant name],

I hope this email finds you well. My name is Rebecca Leach. I am a doctoral candidate under the direction of Dr. Alaina Zanin in the Hugh Downs School of Human Communication at Arizona State University. I am currently working on my dissertation, which explores compassion and burnout in healthcare organizations.

I am reaching out to see if you would be interested and willing to participate in my research. Participants for this study must (1) be at least 18 years of age, (2) currently employed at a healthcare organization, and (3) have worked in their organization for at least one year. I am especially interested in talking to people who have worked with patients during COVID-19.

I would love to hear about your experiences as a healthcare worker. This study involves a Zoom interview that is expected to last approximately one hour. Your participation in this study is completely voluntary, and your identity will be kept confidential. To recognize participants’ time, I am also happy to offer a $50 Amazon gift card for participants who complete the interview.

If you have any questions concerning this study, please contact me at rbleach@asu.edu. I look forward to hearing from you!

Thank you,
Rebecca Leach, M.S.
Doctoral Candidate
Graduate Teaching Associate
Hugh Downs School of Human Communication
Arizona State University
Social Media Flyer

COMPASSION & BURNOUT IN HEALTHCARE

Calling all healthcare workers!
My name is Rebecca Leach. I am a doctoral candidate at Arizona State University, and I am collecting stories about healthcare workers’ experiences. Those willing to share their stories will be asked to participate in a Zoom interview (about one hour). Participants will receive a $50 Amazon gift card for their time.

Who can participate?
This study is open to healthcare workers who are:
1. At least 18 years old
2. Currently working at a healthcare organization
3. Have worked at their organization for at least 1 year

Interested in participating or learning more?
Please contact me at rbleach@asu.edu
Demographic Questions (collected via Qualtrics)
1. What is your gender identity?
   a. Male/man
   b. Female/woman
   c. Other (please specify)
2. What is your age?
3. What is your race?
4. What is your job title?
5. How long have you worked for your current organization? (Years and months)
6. What is your income level?
7. What state do you live in?
8. Is your workplace located in an urban, suburban or rural area?
9. Please indicate the number of levels between you and the highest decision maker in your organization.
   a. *If the actual number of levels is unknown, please estimate.
   b. **If you are the highest level decision maker in your organization, type "0."
10. Please indicate the number of levels between you and the lowest level in your organization.
    a. *If the actual number of levels is unknown, please estimate.
    b. **If you are the lowest level decision maker in your organization, type "0."
11. Please enter the email address to where you would like your $50.00 gift card sent:

Greeting, Reminders, and Emotional Support Information
(This message will be stated after the consent form has been signed, and immediately before the start of the interview.)
Thank you so much for taking the time to speak with me about your experiences today. Before we get started, I would like to reiterate that you are welcome to skip any questions during the interview or stop the interview at any time. You are also free to ask me to stop the recording at any time. I would like this interview to be a comfortable space for you.
I also recognize that this interview may potentially trigger stress or difficult emotions as you reflect on your experiences, which is why I would like to highlight some emotional support resources before we begin:
- The National Alliance on Mental Illness (NAMI) has a helpline where you can receive information, support, and resource referrals for concerns related to mental health. You can call this helpline at 1-800-950-6264, Monday through Friday from 10 a.m.-10 p.m. ET.
- NAMI also has a 24/7 texting crisis hotline with trained crisis counselors. You can text NAMI to 741741 at any time to get started.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) also has a national helpline that provides a treatment referral and information service. You can call 1-800-662-4357 at any time.
Do you have any questions before we begin?
Warm-up Questions
1. Tell me a little bit about how you came to work in your current role in this organization.
   a. What drew you to this job? Why were you interested in becoming a healthcare worker?
2. How do you feel about your workplace in general?
3. What’s a typical day at work like for you?
   a. Can you contrast that typical day to a typical day pre-pandemic?

Experiencing and Recognizing Suffering, Stress, & Burnout
4. Can you tell me about a recent experience in your workplace that made you feel stressed?
   a. Can you provide a specific situation?
   b. Who was involved?
   c. What messages do you remember hearing during the situation?
   d. Were there any normative practices or rules that contributed to your stress in that situation?
5. Thinking back to the beginning of the pandemic, can you identify any turning point event in how you felt and experienced stress in your workplace?
   a. Who was involved?
   b. What messages do you remember hearing during the situation?
   c. Were there any normative practices or rules that contributed to your stress in that situation?
   d. Scholars have defined burnout as being simultaneously disengaged and exhausted at work. Do you feel like your stress over time is escalating into burnout? If so, can you give me an example?
6. When you’re having a tough day at work, what do you do to get through the day?
7. What could your workplace be doing better to manage employee suffering? If you could wave a magic wand and change anything about your organization or job, what would you change and why?
8. I want to take you back to a situation where a coworker was clearly suffering. Ok, now describe that situation.
   a. How did you recognize what was going on? (Did your coworker share their situation with you? If not, how could you tell something was wrong?)
   b. What did that conversation with your coworker look like? Where did it take place?
   c. How common are situations like this in your workplace?
   d. Is this how things typically unfold when a coworker is struggling?
9. Many people often feel uncomfortable expressing personal emotions and struggles at work. Have there been times when you have intentionally chosen to not express your suffering to coworkers?
   a. How did you decide whether to bring your problems up in the workplace?
Structures of Compassion

10. Communication scholars have defined compassion as a process where people recognize suffering in others, relate vulnerably and empathically with that person, and act or react to support them in their suffering. Where, if at all, do you see compassion in your organization? (e.g., among co-workers, superior-subordinate, patient-provider?)
   a. What does it look like?
   b. Do you think organizational policies can be compassionate? If so, what compassionate policies come to mind?

11. In what ways, if at all, does your organization support you or help you thrive at work?

12. In general, how compassionate are your coworkers? Can you provide examples?
   a. Do any role-models of compassion stand out in your mind? Tell me about this person. How does this person behave? How do they communicate?

13. Envision and describe an ideal workspace that feels compassionate.
   a. What does that space physically look like? What objects or resources would you want to be there?

14. When COVID-19 emerged, did your organization introduce any new policies or procedures? What were these, and how did they affect your work?

15. How do you feel about these policies?
   a. How do you feel about your organization’s way of doing things?

Compassion Organizing

16. How do people in your workplace usually talk about their emotions or problems?
   a. What are these conversations usually about? (Work problems? Personal problems?)
   b. Where do these conversations usually occur?

17. Some of the people I have talked to have mentioned a specific way they talk about emotions and problems in the workplace, and I’m curious if it resembles anything in your workplace experience. One participant called it “spiral time”. Essentially, they have moments in the day called “spiral time” where they informally allow each other to vent as much as they need to, but on a specific time limit or limiting the number of times they can spiral each day. Have you seen anything like this in your own workplace? How is this similar to or different from your experiences?

18. How do you think coworkers should support each other if someone is struggling, if at all?

19. Think back to a time where multiple people in your workplace worked together to support a colleague who was suffering. Describe that situation to me.
   a. How did everyone come together in this situation?
   b. What did you all do? What was the outcome?

20. In your workplace, what can someone who is struggling with their job do? (Is there a procedure, someone people generally talk to, etc.?)

Closing Questions

21. Given our conversation today, are there any topics you would like to revisit?
22. Anything else that we haven’t talked about that you would like to share?
23. If I have any follow-up questions on your responses, would you be comfortable
with me contacting you for a short 10-minute follow-up interview in the future?
This follow-up interview would take place in the same format we used today:
conducted via Zoom and recorded with your consent. Like today, you would be
free to skip any questions during the follow-up interview or stop the interview at
any time.

Closing Comments
Thank you again for sharing your stories with me today. I deeply appreciate it. Would
you like me to repeat or go over any of the emotional support resources we discussed at
the start of this interview? (Repeat organizations and phone numbers as necessary.)
Thank you.
APPENDIX D

CONSENT FORM
Dear Participant,

I am a doctoral candidate working under the direction of Dr. Alaina Zanin in the Hugh Downs School of Human Communication in the College of Liberal Arts and Sciences at Arizona State University. I am conducting a research study to explore compassion and burnout in healthcare organizations.

I am inviting your participation, which will involve participating in an interview conducted over Zoom. During the interview, you will be asked to discuss your experiences as a healthcare worker. The expected length of the interview is approximately one hour. You have the right not to answer any question, and to stop participation at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. Participants who complete the interview will receive a $50 Amazon gift card for their participation. This study is open to any participants who: (1) are at least 18 years of age or older, (2) are currently working at a healthcare organization, and (3) have worked at their organization for at least 1 year.

Your responses will be used to better understand how healthcare workers can support each other and cope during times of crisis. There are no foreseeable risks or discomforts to your participation, but you are welcome to choose not to answer any of the interview questions.

I would like to audio/video record this interview. You are free to request that the recorder be turned off at any point during the interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be recorded; you also can change your mind after the interview starts, just let me know.

At the end of the interview, I will ask if you are willing to participate in a short ten minute follow-up interview to follow up on your initial responses, if follow-up or clarification is needed in the future. This follow-up interview would take place in the same format: conducted via Zoom and recorded with your consent. You would be free to skip any questions during the follow-up interview or stop the interview at any time.

Confidentiality will be provided to the extent allowed by law. Your interview responses will be kept as confidential as reasonably possible. In lieu of your real name, we will use a pseudonym to identify your data. This same pseudonym will be used throughout the entire research process. We will not play your audio/video file to anyone. We will have sole access to the file, and it will be kept on a password-protected computer. After the research process is complete, your file will be destroyed. Similarly, we will keep your consent form and transcript on a password-protected computer. We will keep all de-identified transcripts indefinitely and will have sole access to these. De-identified data collected from the current study will be shared with other investigators for future research.
purposes. The results of this study may be used in reports, presentations, or publications but your name will not be used.
If you have any questions concerning the research study, please contact the research team at: rbleach@asu.edu or Alaina.Zanin@asu.edu. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

By signing your name below, you are agreeing to be part of the study.

Sincerely,
Rebecca Leach, M.S.
Doctoral Candidate & Graduate Teaching Associate
Hugh Downs School of Human Communication
Arizona State University
Email: rbleach@asu.edu
Phone: 256-783-2579

Principal Investigator: Alaina Zanin, Ph.D.
Assistant Professor
Hugh Downs School of Human Communication
Arizona State University
Email: Alaina.Zanin@asu.edu

I have carefully read and/or I have had the terms used in this consent form and their significance explained to me. By signing my name below, I agree that I am at least 18 years of age and agree to participate in this project.
RQ1: What structures do healthcare workers describe as enabling and/or constraining compassion in their organization?

<table>
<thead>
<tr>
<th>Structures that Enable and/or Constrain...</th>
<th>Codes</th>
<th>Description</th>
<th>Data Exemplars</th>
</tr>
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<tbody>
<tr>
<td>Recognizing</td>
<td>Healthcare Norm of Emotional Suppression</td>
<td>Healthcare workers described a norm where they felt socially and professionally obligated to mute any emotions of suffering in the workplace.</td>
<td>(1) Amongst each other we try to be very tough, but also in front of the patients. I'm not sure it would be good for them to see us express those emotions, but we still feel the need to be strong and not show those emotions.</td>
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<tr>
<td></td>
<td>Alone-together Workspaces</td>
<td>The design of physical spaces made healthcare workers feel both isolated and connected with coworkers.</td>
<td>(2) The goal is to be like a rock and a river. Like someone who's very sturdy and can be looked to, but also someone very flexible and can kind of go with the flow and can have the perseverance of both. Like a river, you keep chipping away at the same thing and going forward, but also like the perseverance of a rock and that you're very stoic.</td>
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<td>(1) I mean, we have our teams located in... They're called pods. It's a completely open office. So there's pods separated by walls. And then each team has several walled off cubicles but it's an open area so everyone can see each other. I like that style for myself: being able to turn around and be able to see someone if I need to, just reach out and call someone, not to have a closed-off cubicle and have to walk over to them and knock on the cubicle or anything and seeing if anyone's there. And so, I like being able to have everything open where everyone's talking to each other, social, joking around a little bit.</td>
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<td>(2) The way the computers are set up right now, you have a room and they're set up logically along the walls. So that way they take up minimal space and they can get all the outlets and everything like that. But I like the idea that we've talked about before: flipping the script and instead have all the computers face each</td>
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<tr>
<th>Occupational Challenges of Healthcare</th>
<th>Aspects of healthcare work that employees identified as particularly challenging and stressful.</th>
<th>Overwhelming Workload</th>
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<tr>
<td>- Overwhelming Workload</td>
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<td>(1) I still feel like this is my career path and I'm in it for a reason, but it does get harder. It has been getting harder, especially when it's like you have all these crazy sick patients and it's just super stressful and everyone's stressed out. As far as being disengaged, I still feel like I'm able to give my patients what they need and my coworkers what they need, but there are definitely nights where I just kind of shut down. I just need to step back and maybe go take a break or go sit outside for a minute and kind of catch myself from coming apart, just because it's so crazy busy or stressful.</td>
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<td>- Telemedicine and Telehealth</td>
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<td>(2) I feel I'm always on the clock in a way. I'm just always in work mode...There's pressures from [management] just to always put work first over everything. Trying to maintain that dynamic of maintaining a good rapport [with my manager and coworkers] and being a hard worker while also maintaining a good work-life balance can be a challenge.</td>
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Telemedicine and Telehealth
(1) When COVID hit, everything changed. Everything was done by phone. I would do all my meetings by phone, contact with members by phone. I'd have meetings with the other supervisors or clinical teams to update the demand, what's going on with the hospitals. So all the case managers were pretty much working from home.

(2) It’s easier to put up with more bullshit… I don't have to look at your face while you're talking to me and making me angry [when we’re meeting on Zoom].
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<thead>
<tr>
<th>Related Topic</th>
<th>Description</th>
<th>Quotes</th>
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| Relating The Business Model of Healthcare | Participants described their organizational leaders as primarily motivated by “bottom-line” concerns rather than employee and/or patient wellbeing. | (1) And I know this is not unique and that's why I haven't left my organization…is that you feel like administration, especially higher-up administration or corporate, they're up for money. They don't really care about us. They don't really care about the patients unless it affects the bottom-line or their outcomes. They want their outcomes to look good.  
(2) [Management] is crunching numbers, and it feels like we’re just another number. And we have to meet this certain number or else our job feels threatened or the security of our job is on the line. As an organization, as an institution, I don't think there's any compassion there…If you’re feeling upset or burnt out at work, there's no advice for council or ways to make it better or bonding experiences or anything like that. I just feel like that is on the bottom of their priority list. |
| Disconnected Decision-makers | Participants identified a feeling of “disconnect” whenever management and administration communicated decisions and policy changes. | (1) They make their decisions in their comfy chairs in the offices and their fancy lunches when they meet, and they come up with a decision that they did not even see if it’s worse in the workplace or not…They are disconnected completely. They don't have anything to do with the real workplace.  
(2) It would be really nice to see some of these higher-ups come and spend a day on one of our units, where we've had to restrain several kids, where we've had to pick up a kid off the floor because they're sobbing because their parents just said, “You can't come home, we don't want you anymore.” I challenge any of the higher-ups to come and participate in that because they feel so far removed from the compassion that is necessary on our units. |
| Occupational Norm of Appreciation | Participants described an occupational norm in healthcare where messages of appreciation were provided. | (1) I think they try by sending us emails saying, "Good job, team. You're doing great," which is nice. But when they say the same thing in every email, it just seems a little bit not as genuine, so that is kind of disheartening. |
| (Re)acting | Access to Therapy and Mental Health Resources | Participants described the mental health resources that were technically available to them, but also described how such resources felt inaccessible. |
| Turnover and Staffing | Limited Access to Material Resources - Turnover and Staffing - Food | Participants identified material resources that were generally limited or missing in healthcare. |

**Participants** described the mental health resources that were technically available to them, but also described how such resources felt inaccessible.

The hardest part about using those resources is just finding the time to. They have all of these things, but they don't necessarily make time for us to go there. Nobody wants to be there longer than 12 hours, so I don't know a lot of people that use them.

Sometimes it can be presented in a negative way, like, "There's something wrong with you. I think you need to go talk to somebody" instead of, "We have these resources, if you need them."

I think the most helpful thing they could do is overstaff, which sounds ridiculous. But it's almost guaranteed we're going to have at least one person call out every day. But to have adequate staff is not to have all the slots filled, it's to have more than you need. It's such a mood booster when you have somebody floating around, and they're like, "What do you need? What can I help you with?" Just having an extra person. Even if you did the numbers and they weren't actually doing that much more work, the mood boost it gives you is so much more worth it than whatever work they're completing. I think people

frequently communicated yet felt “hollow” and “not genuine.”

I think that it would be nice if they were able to—I don't know exactly how—but show their appreciation more, because they know what's going on and they know how hard we're working. They say it through emails or through these text messages. They say, "Thank you so much for helping us. We really appreciate it," but they're not exactly showing it. Maybe they think they're showing it because we are getting really good incentives and being paid more for working these shifts, which is really nice, but that's not all that matters. So, I don't know what that would look like—if it were like buying us lunch once in a while, or, I don't know, giving us a gift bag. I don't really know, but something to show it, because they don't show it. They just say it.
would be willing to work harder or longer, or just feel better at the end of the day if we had that.

Food
(1) You can't get a hot meal on the weekends anymore anywhere. They have prepackaged sandwiches, and it makes it really difficult. So, you either have to bring food in from home or you wind up ordering out. It used to be that you could get hot breakfast. I mean, there are nights when I go in and I work four PM to four AM, and I've worked the night before, so I've come home and I've slept. And I got up for work at three o'clock, took a shower, threw my scrubs on and I can't even go down to the cafeteria and get a bowl of soup when I get there.

(2) There's a lot that they can do on their end to make the workplace better…So there's a whole day designated "Pharmacy Technician Day," and they gave us an old pin that was just a pin that you can put on your scrubs. And I'm just like, "Dude, order a pizza or something." There was no food given.

RQ2: How do healthcare (re)produce or transform structures related to the communication of compassion in healthcare organizations?

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<tr>
<th>Hierarchical Code (Definition)</th>
<th>Subcodes</th>
<th>Data Exemplars</th>
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<tbody>
<tr>
<td>Acting Compassionately as an Individual</td>
<td>Asking “How Are You” Twice</td>
<td>(1) I do feel like I am able to really read people fairly well when they need to talk more. If I ask a patient or if I ask one of my co-workers, &quot;How are you?&quot; and their answer is a little bit withdrawn, then I ask again, &quot;How are you?&quot; And then typically in that second question, I'll get more truth to their response with either tears and, &quot;I'm not okay.&quot; But if they're like, &quot;Nope, I'm fine,&quot; then I'm going to take their word for it. And then I usually follow it up with, &quot;I'm here if you need to talk.&quot;</td>
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| Sharing Workload | (2) I like the idea of people coming around and checking in. We have a lot of nurse practitioners and I'll check in with a couple that go in and out of the hospital, like, "Hey, how are you doing? Can I help you in any way?" So I think having that, I guess that's what you call it, just a check in. Make sure people are... that their head's above water basically, and if not, well, what do you need?  

(1) At the end of the day, everyone looks out for each other… If somebody's struggling or somebody can't show up or something, you should never say, "That's not my job." I've been my own medical assistant in the past. I've taken my own vitals on patients. I've taken my own intake. Dude, stuff happens. Life happens. So, everyone needs to be there for each other, have great communication to where people can fill in.  

(2) I think it's give and take too. Sometimes I need somebody to switch calls with me or like their kids have a football game, they need to leave early, "Can you cover for me?" If I can, I'm going to help you out because I truly feel what goes around, comes around. And if you're going to be helpful to them, when you need help, they help. |
| Embodying Aboutness | (1) I typically touch all of my patients, whether it's just a pat on the shoulder or on their back when I leave, or actually giving them a hug. Compassion to me is physical, as well as listening and empathy and caring.  

(2) If you're having a bad day, there's always somebody there to give you a hug or like sometimes that we've had a patient that has passed away or something and we can cry together. Just sometimes, like I said, that hug that you need, or even just the “Hi” or “See you later. Have a good night.” Or, “we'll start over tomorrow. Tomorrow will be a better day.” |
| Finding Humor in Pain | (1) I think a lot of times in the ER, we joke about things that probably shouldn't be joked about. But it kind of just makes it easy to just laugh at a situation that you want to cry about. Because sometimes if you don't laugh, you're going to cry. So a lot of times in the ER, we just goof off as much as we can.  

(2) Even when it's a terrible night and it feels like things are collapsing around you, there's always that moment where you look at somebody and...we'll just laugh because things are so outrageously ridiculous. So being able to have those moments of comradery and things like that… It's just huge. So I'm very thankful for that. |
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<tr>
<th>Coordinating Compassion as a Collective</th>
<th>Making and Giving Food</th>
<th>Limiting Spiral Time</th>
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<td>(Healthcare workers described typical ways that a group could come together to recognize, relate, and (re)act to a colleague who is suffering.)</td>
<td>(1) After she had the baby, she found out it was breast cancer. And literally everyone on our unit signed up to babysit her kids and send her food. We had a meal train going for months for her, while she was getting chemo and signing up to babysit her kids, so that when she was sick, she didn’t have to take care of her newborn and toddler that she had. That was really incredible to see, everyone just kind of came together to support her.</td>
<td>(1) We call them spirals. We tell each other, “You get two spirals a day, and that's it.” We jokingly tell people to “get off of their spiral, because you're spiraling too much, and you need to get off of that one.” And so that's just what we tell each other. And like, “You've already had a spiral today or you've had one big one, so that's it for you.” It brings us back down to earth a little bit and tries to redirect to</td>
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<td>(2) So when she passed away, everybody really came together. Made meals for her family, we had a walk to raise money, stuff like that. It was good to see we were still capable of that even through COVID. That was August, which was one of our worst months. It was good to see that we were still able to do stuff like that even in one of our worst months.</td>
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<td>Donating PTO or ETO</td>
<td>(2) We have a sunshine fund where basically, we all donate money to have this kind of like account, I guess, of money so that if someone's family member passes away, or they get sick, or have a baby, we can use those funds to send them flowers, or send them food, which is really a nice thought.</td>
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<td>(1) You can donate ETO, which is earned time off. You can donate your off time and you can donate it to different people</td>
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<td>Creating Informal Committees</td>
<td>(2) We found out that employees can gift her from their PTO. So if we can give her an hour or two, whatever, you can give this technician a PTO. So we planned to give her maybe an hour of each. Of course, nobody's going to give a thousand dollars all of sudden, but at least, an hour or two from the three of us…we could give it to her.</td>
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<td>(1) We had a bracelet, like those plastic jelly bracelet bands that everybody had for a long time. We had those made for her and sold them and then had a link where everybody bought her food and we’ve donated that to help her with her medical costs and things like that…There were a couple girls that just kind of took charge. One of them kind of took over the food drive part of it, and the other one got the bracelet organized and went around unit to unit selling those.</td>
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<td>(2) We have a sunshine fund where basically, we all donate money to have this kind of like account, I guess, of money so that if someone's family member passes away, or they get sick, or have a baby, we can use those funds to send them flowers, or send them food, which is really a nice thought.</td>
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“What's important here?” I know you're mad. I know you're frustrated, and that's how it's going to be for right now. But what's important?

(2) I mean like, "Okay, you can vent for two minutes and then we got to go." Or like, "let me just vent for a second and then turn it off." Definitely heard stuff like that before...but it costs me later. If something was rough or hard, it will come up when I don't expect it. So I can definitely turn it off or compartmentalize or whatever you want to call it to get through the shift, right? But then on a day off or maybe at night or when you have the space or it's safe because people aren't depending on you then, then you feel it.

Modeling Compassion
(Healthcare workers looked for role models of compassion in their workplace and often changed their behavior to match them).

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<tr>
<th>Modeling Compassion</th>
<th>Identifying Role Models of Compassion</th>
<th>Observing and Mimicking Compassion in Others</th>
<th>Practicing Self-Compassion</th>
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<td>I think that's because our boss and the providers show that. I think if they didn't show that, I think my coworkers would not be compassionate as often, if you're not modeled that. I think we're just naturally compassionate, at least my team. All of them are naturally, genuinely worried about anybody. I think it would be masked a little bit more if we didn't have that role model, just because we would be like, okay, I guess I got to be harder on everybody else.</td>
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<td>I'd say one of our doctors is an exceptional role model for compassion. She will come in early if need be to meet with members if they're unable to come in during regularly scheduled business hours, stay late if she needs to, offer assistance with the team. She's willing to listen to any case manager from any team that will come speak with her for an issue to help brainstorm what needs to be done for the member to help them. She's always patient, never gets agitated or irritable. She has a great demeanor and really shows a lot of compassion for all the team members and the patients as well.</td>
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<td>So because the residency recruits compassionate individuals and takes time to recruit those individuals who kind of match that mindset, you're surrounded by that and you're enhanced by it…. I try and keep my eyes open to a lot of it and just like not necessarily be like a chameleon, but…I try and make myself very aware of other people's successes so that I can mimic or steal or copy from them to make myself better.</td>
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<td>It can be very draining to take on other people's things or what they have going on, and you have to have the things that make you feel better. Everybody always uses the analogy of when you're on a plane, if the oxygen mask drops, you have to get your own</td>
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set boundaries to protect their time and energy.)

oxygen mask on before you can help somebody else. You can only actually help others if you're helping yourself too. So I think it's really important that we all take a step back and take the time to say, what fuels me, what makes me feel better so that I can go out and use my energy to help other people feel better too.
APPENDIX F

PROPOSED EXPERIMENT IMAGES
Condition 1: High Food/High Furniture
Condition 2: Low Food/High Furniture
Condition 3: High Food/Low Furniture
Condition 4: Low Food/Low Furniture
APPENDIX G

PROPOSED QUALTRICS SURVEY
Dear Participant,

My name is Rebecca Leach. I am a doctoral candidate under the direction of Dr. Elissa Adame in the Hugh Downs School of Human Communication in the College of Liberal Arts and Sciences at Arizona State University. I am conducting a research study to explore compassion in healthcare workspaces.

I am recruiting individuals who meet the following requirements. Participants must be: (a) 18 years or older, (b) currently employed at a healthcare facility, and (c) have been employed in the healthcare industry for at least 1 year. Participants will complete an online survey that will take approximately 15 minutes to complete. You have the right not to answer any question and to stop participation at any time. Your participation in this study is completely voluntary.

Your responses will be used to better understand how the design of healthcare spaces may impact conversation. There are no foreseeable risks or discomforts to your participation. Your responses will be anonymous. The results of this study may be used in reports, presentations, or publications but your name will not be used.

If you have any questions concerning the research study, please contact me (Rebecca Leach) at rbleach@asu.edu or Dr. Elissa Adame at Elissa.Adame@asu.edu. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

By clicking “accept” and taking the survey, you are agreeing to be part of the study.

[Demographics]

1. What is your age? (in years)

2. What is your gender identity?
   a. Male/man
   b. Female/woman
   c. Other (please specify)

3. What is your race?
   a. White or Caucasian
   b. Black or African American
   c. Hispanic or Latino/a
   d. Native American
   e. Asian American or Pacific Islanders
   f. Other (please specify)
4. What is your highest degree or level of school completed?
   a. High school diploma or GED
   b. Associates Degree
   c. Bachelor’s Degree
   d. Master’s Degree
   e. Professional Degree
   f. Doctorate
   g. Other (please specify)

5. What is your current job title?

6. How long have you worked in the healthcare industry? (years, months)

7. Please indicate the number of levels between you and the highest decision maker in your organization. If the actual number of levels is unknown, please estimate. (If you are the highest level decision maker in your organization, type "0."

8. Please indicate the number of levels between you and the lowest level in your organization. If the actual number of levels is unknown, please estimate. (If you are the lowest level decision maker in your organization, type "0."

Directions: You are about to read a workplace scenario and view a corresponding image. You’ll be asked to respond to that scenario and image throughout the survey.

Please read the scenario carefully and spend time imagining yourself in the space.

Then, respond to the scenario and image.

*Participants will see one of the four conditions; images in Appendix F*

Condition 1: Imagine you just started a new job at a new healthcare facility. On the first day, you walk into the breakroom pictured below. You notice upholstered armchairs and end tables. You also notice a coffee maker, a box of doughnuts, apples, and a refrigerator. You see a coworker sitting nearby. Although you do not know this coworker very well, you can tell from the look on their face that they seem upset.

Condition 2: Imagine you just started a new job at a new healthcare facility. On the first day, you walk into the breakroom pictured below. You notice upholstered armchairs and end tables. You also notice a vending machine. You see a coworker sitting nearby. Although you do not know this coworker very well, you can tell from the look on their face that they seem upset.

Condition 3: Imagine you just started a new job at a new healthcare facility. On the first day, you walk into the breakroom pictured below. You notice a square table and plastic dining chairs. You also notice a coffee maker, a box of doughnuts, apples, and a
refrigerator. You see a coworker sitting nearby. Although you do not know this coworker very well, you can tell from the look on their face that they seem upset.

Condition 4: Imagine you just started a new job at a new healthcare facility. On the first day, you walk into the breakroom pictured below. You notice a square table and plastic dining chairs. You also notice a vending machine. You see a coworker sitting nearby. Although you do not know this coworker very well, you can tell from the look on their face that they seem upset.

[Chance // Opportunity // Willingness (3 sets of semantic differentials)]

1. In this room, there is a high chance you will express compassion to this new coworker.
2. In this room, you are willing to express compassion to this new coworker.
3. This room gives you an opportunity to express compassion to this new coworker.

Likely/unlikely
probable/improbable
agree/disagree
yes/no
right/wrong
true/false
correct/incorrect

[Compassion to others (adapted from Gilbert et al., 2016)]
Participants respond on a scale of 1-10, where 1 = never and 10 = always.

Directions: Keeping in mind the breakroom you have seen, please rate the items using the following rating scale.

Compassion to others (engagement subscale)
When others are distressed or upset by things…

1. This room motivates me to engage and work with other peoples’ distress when it arises.
2. This room allows me to notice and be sensitive to distress in others when it arises.
3. In this room, I would avoid thinking about other peoples’ distress, try to distract myself and put it out of my mind.
4. In this room, I would be emotionally moved by expressions of distress in others.
5. This room allows me to tolerate the various feelings that are part of other people’s distress.
6. This room provides the opportunity to reflect on and make sense of other people’s distress.
7. In this room, I would not tolerate other peoples' distress.
This room allows me to be accepting, non-critical and non-judgemental of other people’s distress.
Compassion to others (action subscale)
When others are distressed or upset by things…
1. In this room, I could direct attention to what is likely to be helpful to others.
2. In this room, I could think about and come up with helpful ways for them to cope with their distress.
3. In this room, I don’t know how to help other people when they are distressed.
4. This room allows me to take the actions and do the things that will be helpful to others.
5. This room provides the opportunity for me to express feelings of support, helpfulness and encouragement to others.

[Giving Emotional Support—Subscale of 2-Way Social Support Scale (adapted from Shakespeare-Finch & Obst, 2011)]
Participants respond on a 6-point Likert scale from 0 (not at all) to 5 (always).

1. This room allows me to listen to other’s problems.
2. In this room, I would look for ways to cheer people up when they are feeling down.
3. People close to me would tell me their fears and worries in this room.
4. This room allows me to give others a sense of comfort in times of need.
5. In this room, people would confide in me when they have problems.

[Emotional Labor Scale (adapted from Kruml & Geddes, 2000)]
Participants respond on a 5-point Likert scale (1 = never, 5 = always)

Emotive effort subscale
1. In this room, I would try to talk myself out of feeling what I really feel when helping coworkers.
2. In this room, I would work at conjuring up the feelings I need to show to coworkers.
3. This room allows me to change my actual feelings to match those that I must express to coworkers.
4. When working with coworkers in this room, I attempt to create certain emotions in myself that present the image my organization desires.

Emotive dissonance subscale
1. In this room, I would show the same feelings to coworkers that I feel inside.
2. In this room, the emotions I show my coworker match what I truly feel.

[Manipulation Check]
1. Would you describe this workplace environment as:
   a. Warm or cold?
   b. Welcoming or unwelcoming?
   c. Comfortable or uncomfortable?
   d. Pleasant or unpleasant?
e. Convenient or inconvenient?

[Open-Ended Section]

1. As you imagine your coworker sitting there, would you talk to your coworker? (yes/no)
2. If yes, describe what you would say to your coworker. Please respond in the box below as if this were a real situation.

If no, imagine you do decide to talk to them. Describe what you would say to your coworker. Please respond in the box below as if this were a real situation