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Date

From Compassion to Satisfaction: Examining the Relationship between Routines that
Facilitate Compassion and Quality of Service

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Abstract

From Compassion to Satisfaction: Examining the Relationship between Routines that Facilitate Compassion and Quality of Service

By Laura E. McClelland

Workplace suffering is both prevalent and costly. Compassion is a means to alleviate suffering, and previous research shows that organizational structures can facilitate compassion in the workplace. However, little is known about how organizations structure to manage suffering, and what effects these structures have on outcomes that matter to organizations. In this dissertation, I examine how one type of structure, organizational routines, can become a way in which organizations structure to mitigate the adverse effects of suffering and, in so doing, improve service quality.

I conduct an in-depth qualitative field study of two hospitals to better understand different types of routines that support the expression of compassion. The qualitative study informs the development and validation of a survey measure of compassion routines. Key informants report on compassion routines as part of a large-scale study of the effects of espoused compassion and compassion routines on service quality in the healthcare industry. Healthcare is particularly noteworthy for high incidences of worker stress and strain, and thus particularly appropriate for understanding how the expression of compassion among employees may mitigate that strain.

Findings show that an organization's use of hiring routines that attempt to select individuals who are likely to show compassion positively relates to patient overall ratings of a hospital as measured by HCAHPS. The use of employee support routines, such as grief rituals in response to the death of an employee, positively relates to the likelihood that patients will recommend a hospital to a friend or family member as measured by HCAHPS. These findings suggest that compassion routines benefit the organization by improving patient satisfaction levels.

Theoretically, these findings contribute to a better understanding of the more macro consequences of compassion structures. These results offer significant practical implications. Hospital ratings and referrals are a means by which organizations maintain or gain market share, and compassion routines that drive HCAHPS scores may help administrators better manage a hospital's market position. Since HCAHPS may be tied to reimbursement rates, compassion routines may also be a means by which administrators improve the financial viability of their organizations.

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1 INTRODUCTION

In 2002, the following quote appeared in an article in the Wall Street Journal describing the cost of workplace grief. Within this article, the journalist provides a brief snapshot of a man named Don Lee. Mr. Lee's story provides a powerful illustration of the consequences of workplace grief. Here is his story:

Two days after his daughter's funeral, Don Lee returned to his job as manager of a business-insurance agency in Dallas. He sat at his desk, thinking about Melinda's stay in an intensive-care unit. The 20-year-old college student had been in a car struck by a drunk driver. Through his workday, Mr. Lee thought about her. "I put in my full eight-hour day," he says, "but for six months, I didn't do more than four hours of work each day"(see for a review, Zaslow 2002).

Suffering and Compassion in Organizational Life

Don Lee is not unique in his suffering. Over 2.7 million workers in the United States (U.S.) experience the loss of a loved one each year. A study in 2003 estimated that workplace grief costs U.S. firms approximately \$75B each year (Grief Recovery Institute 2003). Things like the loss of a loved one, divorce, family crises, and even the loss of a pet can affect worker performance. Employees bring "their whole selves to work" (Meyerson 1998) even if they don't want to or intend to. Work is suffused with joys and sorrows from both work and personal lives (Worline and Boik 2006). Grief, sadness, and stress are all forms of suffering that exist in everyday organizational life (Frost 2003). Employees continually struggle with personal and work-related losses and setbacks, and these forms of suffering exist quite often at a significant cost not only to the welfare of the individual dealing with them, but to the organization as well. When suffering is either ignored or not handled effectively, previous research shows that suffering results in

negative consequences such as reduced productivity, poor performance, (Frost 2003, 2004) burnout,(e.g. Kahn 1993; Maslach and Goldberg 1998) and even workplace violence (Pearson and Porath 2005). Whether it is recognized or not, organizations and their employees are significantly affected on an ongoing basis by human suffering.

Compassion, on the other hand, is triggered by human suffering. It consists of three subprocesses—noticing, feeling (empathetic concern), and responding to the suffering of an other (Kanov et al. 2004). Because compassion is a process by which people attempt to relieve the suffering of others, it has a significant potential to transform an organization. Compassion may help members cope with their everyday struggles that can quite often impair members' abilities to do their best work. Compassion can also foster organizational capabilities for cooperation in addition to helping members cope with their own pain and challenges (Dutton, Lilius, and Kanov 2007). In a recent study, Dutton and colleagues found evidence to support a model where the social architecture of an organization, including routines, networks, values, and symbolic actions, facilitated compassion organizing (Dutton et al. 2006). Such social architecture may be a means by which organizations manage the costly effects of workplace suffering.

Opportunity for Additional Research

Despite the insights from Dutton and colleagues' work (2006), we still know very little about structures that foster compassion, how these structures relate to workplace suffering, and what impact these structures have on important organizational outcomes. An extensive literature by organizational scholars has typically looked to understand how organizations use various structures in order to promote performance by improving cognitive efficiencies and reducing complexity (March and Simon 1958; Simon 1981;

Cohen et al. 1996; Cohen 2007; Cohen and Bacdayan 1994) reducing variability (March 1991), and creating dynamic capabilities (Teece and Pisano 1994; Teece, Pisano, and Shuen 1997). As a result, such work has left us with a deep understanding of how leaders and managers use structures to facilitate behaviors necessary for better performance. More rarely, scholars have looked to structures for ways that they may shape discretionary behaviors, such as compassion. Dutton and colleagues' case study suggests that when structures legitimate and promote compassion subprocesses, these structures can facilitate compassion. These structures may then help organizations structure to manage suffering. How organizations structure to foster compassion remains unclear. What effects such structures have on important organizational outcomes is also unknown.

Purpose of Study

In this dissertation, I aim to fill this gap. I study a very common structure of interest to many scholars of organizational theory—routines. Routines are one form of structure (Cohen and Bacdayan 1994; Dutton et al. 2006) consisting of patterns of repetitive interactions by multiple actors (Cohen et al. 1996; Feldman and Pentland 2003). They are the means by which organizations do work (March and Simon 1958; Nelson and Winter 1982; Cyert and March 1963), and previous research has linked routines with compassion (Dutton et al. 2006). In looking to routines as a way of studying structural constraints on behavior, I focus on types of routines that have been well documented and studied by organizational scholars. Hiring, socialization, employee support, rewards, leadership, and communication are all routines that scholars have examined in order to document effects on employee actions. I focus on how these routines may become vehicles for the expression of compassion in the workplace, and what effects such

routines have on organizational outcomes such as service quality in large organizations. I call these routines “*compassion routines*.”

I situate my research in the healthcare industry. This context is a logical choice for studying compassion routines and their effects. Compassion is often considered a moral imperative in the way that care is provided to patients and their families given the kind of pain and suffering that is experienced by patients and families (Brody 1992). However, the work environment itself is especially noteworthy for the high degree of emotion work that caregivers engage in. It is a type of emotional labor where healthcare professionals are “toxin handlers,” dealing with emotionally toxic interactions on a daily basis (Frost 2003, 2004). This type of work is associated with a high incidence of strain, burnout, and compassion fatigue (Abendroth and Flannery 2006; Figley 1995; Maslach 1982). All of these adversely affect the quality of care provided. In fact, scholars and practitioners alike continue to advocate for the need to “care for the caregivers” (Abendroth and Flannery 2006; Payne 2001; Olofsson, Bengtsson, and Brink 2003; Mallett et al. 1991; AbuAlRub 2004; Kahn 1993).

This dissertation examines and empirically tests the relationship between these routines and service quality. I accomplish this through the following studies: (1) a rich field study in two healthcare organizations to better understand compassion routines and inform the development of the compassion routines survey instrument, (2) an instrument development and validation pilot study of the compassion routines instrument, and (3) an empirical analysis and test of compassion routines and patient satisfaction using the compassion routines instrument and archival data from a random sample of 675 U.S. healthcare organizations.

Proposed Contributions

This dissertation makes several primary contributions to organizational and health services research. First, this dissertation moves beyond a single case study to provide greater support for ways that organizations can structure to manage suffering and support the expression of compassion through routines. The multi-hospital field study and subsequent large scale survey data provide evidence of compassion routines on an on-going basis rather than in response to a singular event. This suggests that compassion routines are, to a certain extent, sustainable. They can become a kind of organizational capability (Lilius, Worline, et al. 2011). Sustainability implies duration, a characteristic appropriate for studying the relationship between compassion routines and organizational outcomes that reflect performance over a period of time.

Second, previous research has shown the effects of interpersonal compassion using an individual-level compassion survey instrument (Lilius et al. 2008). While this instrument allows scholars to measure and test the micro consequences of compassion, it does very little to help scholars measure and understand the macro consequences of compassion. Organization-level measures of compassion are still needed (Lilius, Kanov, et al. 2011). Thus, the second contribution of this dissertation is the development of the compassion routines survey instrument, an organization level measure designed to measure the existence and usage of compassion routines.

Third, this study moves beyond case studies linking structures to compassion outcomes by performing a large scale test of the empirical relationship between routines and service quality. This study looks at the relationship between compassion routines and one measure of service quality in healthcare organizations—patient satisfaction. Finally,

linking organizational routines to service quality informs an understanding of how hospitals can structure for effective care quality. Because this study examines routines that extend beyond patient-caregiver interactions, its findings are relevant not only for the healthcare industry but generalizable to other service organizations as well.

Outline of Dissertation

This dissertation is organized as follows. In Chapter 2, I review the relevant literature on compassion, organizational routines, and service quality in order to develop a theoretical framework to present propositions related to compassion routines and service quality. In Chapter 3, I describe two studies. The first is a field study describing how organizational routines support the expression of compassion, and I present the findings from this qualitative research. In the second study, I describe the instrument development and validation process of the compassion routines survey instrument using a pilot study. This study builds off of the findings from the qualitative study. This chapter concludes with testable hypotheses based on Chapter 2's propositions and the available empirical measures. In Chapter 4, I describe a large scale empirical study designed to test the relationship linking routines to patient satisfaction. This study uses the compassion routines survey instrument described in Chapter 3 and existing archival data. In Chapter 5, I discuss relevant findings and theoretical and practical implications of this study. Finally, I highlight the key contributions of this work as well as future avenues for research.

2 THEORETICAL FRAMEWORK

2.1 Compassion in Organization Studies

Compassion consists of three processes—noticing, feeling, and responding to suffering (Kanov et al. 2004). Compassion is beneficial to organizations because it results in greater affective commitment and positive emotions (Lilius et al. 2008), positive patient health outcomes (Taylor 1997), and positive evaluations of service quality (Buller and Buller 1987). If structures can and do facilitate compassion as Dutton and her colleagues suggested (2006), then it is important to understand how these structures foster compassion. It is also important to understand the effect these structures have on organizational outcomes like measures of service quality such as client and patient satisfaction. I propose that compassion structures benefit an organization by improving service quality through the management of suffering. In order to unpack the relationship between compassion structures and service quality, I first provide a brief review of the service quality literature, focusing on one form of service quality—client satisfaction. Then, I make three general theoretical claims which I describe in greater detail below.

2.2 Service Quality: Understanding Client and Patient Satisfaction

Client satisfaction has been widely studied across a variety of disciplines—management, marketing, and within specific industry research such as health services. Client satisfaction has generally been defined as a consumer's fulfillment response. It is a judgment that the product or service procured provided a pleasurable experience for the consumer (Oliver 1997). Satisfaction is a psychological process. It is shaped by the consumer's expectations and their actual experiences (Parasuraman, Berry, and Zeithaml

1991). Expectations can be formed from a variety of sources such as promotional claims, word of mouth, third party information, and service or product cues (Oliver 1997; Zeithaml, Berry, and Parasuraman 1993). Interestingly, the features that consumers use to select a product or service provider may not necessarily be the features they use to even evaluate it, making satisfaction a complex but important construct for organizations to understand. In healthcare, satisfaction refers to patient satisfaction. Health services researchers define it as the personal evaluation of care that cannot be known by observing care directly (Ware et al. 1983). Patient satisfaction is the fulfillment of positive expectations (Sitzia and Wood 1997). Previous research has shown that interpersonal aspects of care are the primary drivers of patient satisfaction (Sitzia and Wood 1997; Kadner 1994; Krause 1993; Blanchard et al. 1990). In fact, displayed empathy and compassion positively relate to patient satisfaction ratings (Buller and Buller 1987; Leiter, Harvie, and Frizzell 1998; Krause 1993).

Generally speaking, satisfaction is fundamentally important to organizations as it predicts patronization and repeat exchanges. In markets where consumers have a choice in providers, managing client satisfaction matters because it is a way of maintaining or gaining market share for these organizations (Leiter, Harvie, and Frizzell 1998). Studies have shown that in some industries, client satisfaction is crucial for word-of-mouth referrals (e.g. Schneider 1980). It has been estimated that in healthcare, customer word-of-mouth or loyal customer outreach is equal to two or three times the customer's own value as a patient (MacStravic 1995; Winston 1988). Patient satisfaction is not only good for business though, it is also good for patients. Higher patient satisfaction is associated with improved outcomes for patients such as lower inpatient mortality rates and improved

guideline adherence (Glickman et al. 2010). Research has shown that high patient satisfaction is an indicator of quality, and recent legislation seems to support this view. The Patient Protection and Affordable Care Act (PPACA) includes a value-based purchasing initiative that will tie Medicare reimbursement to HCAHPS patient satisfaction ratings (Hospital Consumer Assessment of Healthcare Providers and Systems) beginning in 2013 (Studer, Robinson, and Cook 2010). Understanding how hospitals can manage service quality becomes increasingly important in light of this recent legislation. Structures which shape service quality, such as compassion and interpersonal aspects of caregiving, may be a means to manage those scores.

2.3 Espoused Compassion and Organizational Structures

Scholars have argued that organizational members share a set of underlying assumptions about the way an organization works and its purpose (Bartunek 1984; Ranson, Hinings, and Greenwood 1980). They refer to these assumptions as interpretive schemes (Bartunek 1984; Ranson, Hinings, and Greenwood 1980). These schemes are used by members to guide their behaviors at work. Interpretive schemes shape organizational structures, and structures tend to be symbolically aligned and consistent with the underlying assumptions of the organization (Thompson 1973; Bartunek 1984; Ranson, Hinings, and Greenwood 1980). Although members within an organization share a set of underlying assumptions about the organization, these interpretive schemes are likely to vary across organizations. Since structures do tend to align with these schemes, variation in interpretive schemes should result in variation in the structures.

Relationship between Articulated Interpretive Schemes and Structure

Variation in interpretive schemes may indeed predict variation in structure. However, interpretive schemes are a shared understanding of the principles of an organization. They are difficult to observe. Many organizations often attempt to make explicit those underlying assumptions by articulating their interpretive schemes. These articulations are known as an articulated interpretive scheme. Articulated interpretive schemes include statements of mission, purpose, and values (Bartunek 1984; Ranson, Hinings, and Greenwood 1980). These articulated interpretive schemes can be an indication of the actual interpretive schemes within an organization. Since organizational structures tend to align with the interpretive schemes (Bartunek 1984; Ranson, Hinings, and Greenwood 1980; Thompson 1973), the articulated interpretive schemes serve as an indicator for the structures in use within an organization. In a case study of the Catholic Church, Bartunek (1984) examined the relationship between changes in the articulated interpretive scheme of the Church after the Second Vatican Council and its organizational structures. Bartunek found that changes to the religious order's doctrines, their articulated interpretive schemes, resulted in significant structural changes as well. In another study, a change in firm policy (an articulated interpretive scheme) was reflected in a change in routines as well (Reynaud 2005). Other scholarship has also examined articulated interpretive schemes, and these studies refer to them as espoused values (Daly, Poudier, and Kabanoff 2004; Meglino and Ravlin 1998; Gruys et al. 2008; Cha and Edmondson 2006; Argyris and Schon 1978).

Espoused values are defined as values articulated by leadership on behalf of the organization. Such values are either the organization's shared values or desired values

that represent the organization's ideals (Daly, Pouders, and Kabanoff 2004; Schein 1985). Although some scholars note that espoused values may be inconsistent with the underlying shared values of an organization (Schein 1985; Meglino and Ravlin 1998; Cha and Edmondson 2006), a limited amount of research has found a significant relationship between espoused values and organizational outcomes. One study found that when merging firms have similar espoused values, organizational performance is higher than those firms that merge with less similar espoused values (Daly, Pouders, and Kabanoff 2004). Similarity in structure and schemes could be one way of explaining performance differences. These findings suggest that similar espoused values between merging firms is indicative of similar interpretive schemes and organizational structures. As a kind of articulated interpretive scheme, espoused values function as an indicator of the interpretive schemes in use and thus the underlying structures as well.

An increasing number of organizations, including service organizations, espouse values in their mission statements. One context in which this is especially true is in the field of healthcare. Most hospitals have mission statements and many espouse values in their statements. The extent to which these service organizations espouse or do not espouse compassion is likely to reflect the extent to which underlying structures foster compassion in the workplace. Thus, the first theoretical claim I make is:

- (1) Organizations that espouse compassion in their mission statements are more likely to have underlying structures that support the expression of compassion than organizations that do not (see Figure 1).

[Insert Figure 1 Here]

2.4 Routines

Given that organizational structures are likely to align with espoused compassion, I focus on one type of structure—routines, which previous research has linked with

supporting the expression of compassion (Dutton et al. 2006). Routines are central to organizations because they are the means by which organizations accomplish work (March and Simon 1958; Nelson and Winter 1982; Cyert and March 1963). Routines are defined as the “repetitive, recognizable patterns of interdependent actions, carried out by multiple actors” (Feldman and Pentland 2003). Routines are the ways people repeatedly do their work. These routines can be a source of inertia (Hannan and Freeman 1983) and a source of flexibility and change (Feldman 2000; Feldman and Pentland 2003). Routines are considered a major source for speed and reliability in organizational performance because they are a kind of structure for collective actions (Cohen and Bacdayan 1994). According to Cohen and Bacdayan (1994), routines are stored as distributed procedural memories. Thus, members draw upon their own procedural memories to enact their portion of the routine, and when members do so, patterns of interdependent actions emerge.

Routines serve as guides for what behavior is normal, expected, and appropriate. They are the ways people think about the way they do their work (Ranson, Hinings, and Greenwood 1980; Bartunek 1984; Cohen and Bacdayan 1994). Routines are repeated actions that draw upon a shared template for how work is performed (Feldman and Pentland 2003). Routines, as structure, shape automatic actions that individuals take and carry out in organizations. Feldman and Pentland describe two parts of a routine that are recursively related—the ostensive and the performative (Feldman and Pentland 2003). The ostensive aspect is the schematic or template of the routine. It is the generalized idea of the routine; it exists as a combination of standard operating procedure and taken-for-granted norms (Feldman and Pentland 2003). Members draw upon the ostensive aspect as

a template for action. It is a shared set of assumptions for how the routine should be performed. The performative aspect refers to the practice of the routine.

Performances of routines consist of specific actions by specific people in specific places and times. Performances are somewhat novel because employees draw upon the ostensive and reflect on appropriate courses of action given the unique circumstances in which they perform a routine. As such, the ostensive and performative parts create and recreate the ostensive aspect of the routine, and the ostensive constrains and enables performances (Feldman & Pentland, 2003). Thus, I make the second theoretical claim:

- (2) Routines impact people's everyday experiences in two ways—how they think and how they act (see Figure 2).

[Insert Figure 2 Here]

2.5 Linking Compassion Routines to Service Quality: Structuring to Manage Suffering

Because routines shape both how people think of their work and how they act in their work, routines can impact outcomes that matter to organizations. When organizations have more structures in place that foster the expression of compassion, service quality should improve in two ways. First, when organizations have more routines that foster the expression of compassion, compassion becomes a part of how service is provided to patients and their families. Previous studies by organizational and health services scholars have shown that compassionate behavior towards customers is a way of providing high quality service (O'Donohoe and Turley 2006; Buller and Buller 1987; Leiter, Harvie, and Frizzell 1998; MacStravic 1995; Winsted 2000). For health service organizations, compassion is particularly important because research shows compassion positively relates to better patient health outcomes (Taylor 1997). Compassion also

positively impacts ratings of patient satisfaction (Buller and Buller 1987; Leiter, Harvie, and Frizzell 1998), which is a measure of service quality. One study found that patient satisfaction positively related to doctors that practiced compassion towards patients during office visits (Buller and Buller 1987). A second study found that terminal patients and their families also reported a more positive experience in a care setting when caregivers were compassionate (Wenrich and Curtis 2003). A third study found that compassionate care by nursing staff positively related to patient satisfaction (Leiter, Harvie, and Frizzell 1998).

Previous organizational research has also shown that the experience of compassion is associated with positive affective experiences (Lilius et al. 2008). In healthcare work, affective rather than technical aspects of care are highly correlated with patient satisfaction and such affective aspects include the effects of practiced compassion (Taylor, Hudson, and Keeling 1991). Marketing research has shown that while reliability in service encounters is what enables organizations to meet client expectations (Parasuraman and Zeithaml 1991), it is the service encounter itself that allows organizations to exceed expectations, and be competitive in the market (Winsted 2000; Parasuraman and Zeithaml 1991). It is not surprising, then, that caring and compassion are considered crucial dimensions of the health service encounter because they shape perceptions of quality of service including client satisfaction (Winsted 2000).

The second path by which compassion routines impact service quality is more indirect. As previously noted, grief and stress are common in the workplace (Frost 2003, 2004; Meyerson 1998; Maslach 1982; Maslach, Schaufeli, and Leiter 2001). Suffering can be costly for an organization because it negatively impacts worker productivity (Frost

2003, 2004; Maslach 1982; Maslach, Schaufeli, and Leiter 2001). Grief and stress limit psychological availability, a predictor of psychological engagement at work (Kahn 1990).

For service organizations such as healthcare providers, expressions of humanity are a required part of the service encounter. Employees that perform a high degree of emotional labor, defined as a job that involves emotion and emotional communication (Miller 2007; Mumby and Putnam 1992), or deal with significant work-related stressors, are at a significant risk for burnout (Leiter, Harvie, and Frizzell 1998; Maslach 1982) including compassion fatigue (Figley 1995; Maytum, Heiman, and Garwick 2004; Abendroth and Flannery 2006). Burnout is a psychological condition in response to chronic stressors on the job. It is a form of workplace suffering. It consists of overwhelming exhaustion, cynicism, detachment from the job, and lack of professional efficacy (Maslach and Goldberg 1998; Maslach, Schaufeli, and Leiter 2001; Cherniss 1980). Burnout impairs employees' abilities to do good work because individuals are less able to cope with the demands of their jobs. Studies have shown that burnout negatively relates to performance and an increased likelihood of quitting (Maslach, Schaufeli, and Leiter 2001; Leiter 1992). Compassion fatigue, a type of burnout, impacts caregivers such as nurses, clergyman, and social workers (Figley 1995; Abendroth and Flannery 2006; Payne 2001). It impairs the ability to provide compassionate care and other forms of emotional labor. Burnout impedes service delivery and negatively impacts client satisfaction by limiting employees' abilities to engage in their work and provide compassion and caring in service encounters (Abendroth and Flannery 2006).

Incorporating the practice of compassion into service exchanges helps organizations not only attend to client suffering, but also attend to employee suffering as

well. Managing suffering may be a means by which service organizations sustain the successful delivery of service and maintain service quality. Thus, the final theoretical claim is as follows:

- (3) Compassion routines should impact service quality in two ways—compassion actions towards patients and compassion actions towards employees (see Figure 3).

[Insert Figure 3 Here]

Linking Espoused Compassion to Service Quality

Given these three theoretical claims, I argue that organizations that espouse compassion are more likely to have underlying structures in place that support the expression of compassion. This, in turn, should positively relate to service quality because compassion routines positively impact the customer experience both directly and indirectly by managing the negative effects of workplace suffering. Thus, I propose the following:

Proposition 1: The greater the espoused compassion, the greater the service quality.

Although espoused compassion should positively relate to quality of service, articulated interpretive schemes are only a rough proxy for the actual structures in use within an organization. So, it is faulty to assume that, just because organizations similarly espouse certain values such as compassion, these organizations should also have similar organizational routines that facilitate compassion. Rather, these organizations are simply more likely than those who do not espouse certain values to have routines that align with those values. The extent to which articulated interpretive schemes positively relate to the quality of service should be a function of the consistency of the organization's routines with its articulated interpretive schemes. So, although articulated interpretive schemes are

an indicator of the underlying structures, they are imprecise. The effect, then, of this relationship may be small. It becomes equally important to also study the specific structures in use in order to better understand to what extent different kinds of structures facilitate compassion and how that impacts service quality.

2.6 Types of Routines That Facilitate Compassion

This study focuses on the ostensive aspects of organizational routines (Feldman and Pentland 2003). I focus on ostensive aspects of routines because I am interested in understanding what organizations can do to create structures that would be conducive to generating compassionate behaviors from their employees. In other words, I am interested in how organizations can encourage compassionate behaviors from their employees. As such, the organizational design of structures that enable compassion, as reflected in the ostensive aspects of compassion routines, is important. I examine specific kinds of routines within an organization that can become a vehicle for the expression of compassion. I focus on types of routines that have been well documented and studied by organizational scholars. Hiring, socialization, rewards, communication, leadership, and support are all routines through which organizations attempt to facilitate desired behaviors necessary for effective service. These routines have also been well-studied. Yet, these routines have not been linked to compassion as part of the human service role. I propose that these routines will moderate the relationship between espoused compassion and service quality (see Figure 4). I describe each of these routine types in greater detail.

[Insert Figure 4 Here]

2.6.1 Hiring Routines

Hiring consists of repeated patterns of actions in order to select and hire employees that are a good fit for the organization. Scholars have addressed fit in a number of studies (for reviews, Kristof 1996; Verquer, Beehr, and Wagner 2003; Hoffman and Woehr 2006). The majority of hiring research involves Person-Organization Fit (P-O fit) studies that examine values congruence (Kristof 1996; Hoffman and Woehr 2006). Values congruence is defined as the extent to which an individual's values are similar to another individual's, or aggregate's, shared values (cf. Meglino and Ravlin 1998). Values congruence studies are based on the assumption that when an individual's values are similar to a fellow employee's, a supervisor's, or those of the organization, then the employee will be more likely to engage in organizationally desired behaviors (see for review Meglino and Ravlin 1998).

This literature finds that perceived values congruence is most predictive of new-hire behaviors such as job acceptance and job hiring (Cable and Judge 1996, 1997). If an applicant or hiring manager perceives values congruence between the applicant and those values which are espoused, then hiring could be one routine for explaining how organizations structure to facilitate compassion. Organizations can evaluate applicants based on whether or not they are inclined to engage in compassion acts. A hiring routine like this should result in more offers being extended to those whose values appear to align with the organization's value of compassion.

Perceived values congruence also predicts job selection. Applicants who are inclined to show compassion, and who feel that such behavior is consistent with the kind of organization in which they want to work, are more likely to accept jobs that discuss

compassion during the hiring routine. The more organizations use hiring routines that select employees who are inclined to notice, feel, and respond to the suffering of others, the more employees should practice those behaviors. When that happens, quality of service should be greater. Therefore, I propose the following:

Proposition 2: The greater use of hiring routines that select employees who are inclined to notice, feel, and respond to the suffering of others, the greater the organization's service quality.

Because articulated interpretive schemes (espoused values) are an indicator of the underlying structures of an organization, articulated interpretive schemes are an indicator of organizational routines. Structures are the means by which compassion is fostered. So, the relationship between articulated interpretive schemes and service quality should strengthen when at least one kind of structure, hiring routines, is consistent with the articulated scheme. The relationship between espoused compassion and service quality should strengthen when hiring routines support the expression of compassion. Therefore, I propose the following:

Proposition 3: The greater the use of hiring routines that select employees who are inclined to notice, feel, and respond to the suffering of others, the stronger the positive relationship between espoused compassion and the organization's service quality.

2.6.2 Socialization Routines

Another kind of routine that can facilitate compassion is a socialization routine. Socialization is the process through which an employee acquires the behaviors, attitudes, and knowledge needed to engage as a member of the organization. This is how an organization ensures continuity of its values and norms (Van Maanen and Schein 1979; Cable and Parsons 2001). Organizations use socialization routines to facilitate behaviors

necessary to accomplish service goals. Regular socialization acts to routinize how employees do their work and how they feel when doing it (Hochschild 1983). The more organizations use socialization practices that routinize noticing, feeling, and responding to the suffering of others, the more that behavior should result in the workplace. When that happens, quality of service should be greater. Therefore, I propose the following:

Proposition 4: The greater the use of socialization practices that routinize noticing, feeling, and responding to the suffering of others, the greater the organization's service quality.

Similarly, the relationship between articulated interpretive schemes and service quality should strengthen when at least one kind of structure is consistent with the articulated scheme. Thus, the relationship between espoused compassion and service quality should strengthen when socialization routines facilitate compassion. Therefore, I propose the following:

Proposition 5: The greater the use of socialization practices that routinize noticing, feeling, and responding to the suffering of others, the stronger the positive relationship between espoused compassion and the organization's service quality.

2.6.3 Rewards Routines

The third type of routine, rewards, influences behavior by drawing attention to and reinforcing valued behaviors (Locke 1977). Rewards reinforce certain kinds of actions or behavior by directing efforts to rewarded behaviors. They also serve as a signal to others for how they ought to behave (Kerr and Slocum 1987; Schein 1985).

Organizational control of these rewards allows organizations to shape action towards organizational goals (Lawler 1971, 1973, 1977). Organizations can systematize these rewards through rewards systems which use behavioral criteria (Gruys et al. 2008) to

assess employee performance and reward behaviors. Rewards include benefits such as promotions and pay increases. Organizations can also use a variety of other less tangible forms of rewards including praise, public recognition, or other benefits that are valued by the employee (Kerr and Slocum 1987). Organizations may actively attempt to transform espoused values into valued discretionary behaviors by aligning rewards with the behaviors necessary to achieve those service goals. In fact, prosocial behavior research finds that rewards predict prosocial behaviors (Podsakoff, MacKenzie, and Bommer 1996; Podsakoff et al. 2000) and compassion is a form of prosocial behavior¹. So, the more organizations use rewards to recognize compassion, the more compassion subprocesses should result. When that happens, service quality should be higher.

Therefore, I propose the following:

Proposition 6: The greater the use of rewards systems that reinforce noticing, feeling, and responding to the suffering of others, the greater the organization's service quality.

Furthermore, the relationship between articulated interpretive schemes and quality of service should strengthen when rewards routines are consistent with the articulated scheme. So, the relationship between espoused compassion and service quality should strengthen when rewards routines recognize the practice of compassion. Therefore, I propose the following:

Proposition 7: The greater the use of rewards systems that reinforce noticing, feeling, and responding to the suffering of others, the stronger the positive relationship between espoused compassion and the organization's service quality.

¹Compassion is a form of prosocial behavior (see for a review, Podsakoff et al. 2000), but it is important to note that the construct is distinct from prosocial behavior because unlike prosocial behavior, the compassionate response is always preceded by the noticing of pain and empathetic concern for another. Thus, compassion is a type of prosocial behavior, but not all prosocial behavior is compassion.

Organizations use rewards routines to reinforce and promote valued behaviors. Another kind of routine used to influence behaviors is a communication routine.

2.6.4 Communication Routines

Communication routines are used as a frequent means to convey information and influence employee behaviors. Communication routines are recurrent and socially embedded communicative actions occurring in an organization which rely on a set of organizational media to convey information (Feldman 2000; Yates and Orlikowski 1992). Organizations use communication routines to disseminate organizational goals and interpretive schemes. Communication routines convey and reinforce core values. Communication routines often include the creation and dissemination of symbols which are “things that stand for the ideas that compose the organizations” (Rafaeli and Worline 2000). Organizations use these symbols in order to transmit messages to members and remind them of the organization’s goals, values, and appropriateness of certain behaviors (Rafaeli and Worline 2000). The kinds of symbols that organizations use varies, but includes such things as office décor, artwork, attire, and token artifacts such as mugs, key chains, and other items that often serve both instrumental purposes as well as symbolic ones (Rafaeli and Vilnai-Yavetz 2004; Jones 1993). For example, when an organization distributes mugs emblazoned with the word “compassion,” not only does it provide something that employees can drink their coffee out of, but the organization sends a message to employees about the appropriateness of compassionate behavior at work. Thus, the use of symbols in communication routines can serve to propagate and legitimate compassionate behavior at work.

In addition to symbols, organizations use other communication media (Watson-Manheim and Belanger 2007) to promote compassion and coordinate compassionate responding. Organizations may use email to send messages containing notification of harm of an employee (Dutton et al. 2006) to other employees. This routine creates greater awareness of an employee's suffering, and makes it more likely that empathy and compassionate responding will result. We see evidence of this in Dutton and colleagues (2006) study of a housing fire at a business school campus, "BTUBS." At Cisco Systems, the Serious Health Notification System is a communication routine where employees notify the chief executive officer (CEO) when an employee or their family member is seriously ill or has passed away (Kanov et al. 2004; Lilius et al. 2008). This routine uses communication media to expedite the notification and coordinate a response. Routines like the ones at Cisco and BTUBS coordinate a compassionate response. Their recurrent performances also further legitimate and propagate noticing, empathetic concern, and responding to those who are suffering.

These routines remind and evoke the appropriate feelings, thoughts, and behaviors necessary for employees' everyday work activities (Schultz, Hatch, and Ciccolella 2006). The use of such routines should then relate to an increased likelihood that employees engage in those behaviors. The greater the use of communication routines that draw attention to the noticing, feeling, and responding to the suffering of others, the more likely that behavior should result. When that happens, quality of service should be greater. Therefore, I propose the following:

Proposition 8: The greater the use of communication routines that draw attention to the appropriateness of noticing, feeling, and responding to the suffering of others, the greater the organization's service quality.

The relationship between articulated interpretive schemes and service quality should strengthen when communication routines are consistent with the articulated scheme. Thus, the relationship between espoused compassion and service quality should strengthen when communication routines support the practice of compassion. Therefore, I propose the following:

Proposition 9: The greater the consistency in communication routines that draw attention to the appropriateness of noticing, feeling, and responding to the suffering of others, the stronger the positive relationship between espoused compassion and the organization's service quality.

2.6.5 Support Routines

Scholars from various disciplines recognize that employee support is necessary in order to manage suffering and reduce burnout (Maslach and Goldberg 1998; Abendroth and Flannery 2006; Mallett et al. 1991; Olofsson, Bengtsson, and Brink 2003). Much of this work has examined social support as the perceived support of one's colleagues and supervisor (AbuAlRub 2004; Mallett et al. 1991). I define employee support routines as recurrent patterns of behavior that include the use of programs (Hartwell et al. 1996; Grant, Dutton, and Russo 2008), resources, and practices to provide support to employees facing hardships or to improve well-being. Support routines consist of coordinated action in order to manage suffering. Organizations use these support routines to mitigate the costs associated with employee suffering (Hartwell et al. 1996) from such conditions as stress, burnout, and grief.

Support routines vary in their nature. Some types include the regular use of employee assistance programs (EAPs), which employees use to seek access to counseling, medical treatment, or other types of personal assistance (Hartwell et al.

1996). Employee charitable acts are another form, this includes the donation, coordination, and distribution of money, vacation time, and other resources to support employees in need (Grant, Dutton, and Russo 2008). Evidence of these support routines exist at places like Foote Hospital in Michigan where employees donate vacation time into a pool which is then given to someone facing hardship (Worline and Boik 2006). Other examples include a program at Vanderbilt University Medical Center (VUMC) called the Partners in Caring Program (Ewing and Carter 2004). In the VUMC neonatal intensive care unit, the staff provides and receives information about support resources available to help with the emotional demands of their work. Members conduct sessions examining stress and anger management, and emotions. Part of the routine also includes the use of support groups to provide support for employees dealing with challenges and stressors in their job. Finally, Schwartz Rounds[©] are in use in 230 healthcare facilities across the U.S. This routine is used to frequently bring caregivers together to discuss the social and emotional issues they face in caregiving, and to alleviate stress associated with recent difficult cases (Schwartz Center 2011).

The extent to which support routines at places like Foote and VUMC are in use is a way of understanding the extent to which employee support routines foster compassion and attend to suffering in organizational life. Because these routines legitimate compassion and suffering in the workplace, it is more likely that employees will show compassion to one another. It is also more likely that employees who are suffering will seek assistance. So, not only will employees view suffering as a normal condition, but they will also be aware of how to seek and give help. We know that suffering impairs an employee's ability to do good work. Support routines manage suffering in order to enable

employees to do better work. This should positively affect quality of service because employees will have the capacity to engage in their work and show compassion to patients and families and to one another. Research linking perceived organizational support to prosocial behavior supports this logic (Podsakoff, MacKenzie, and Bommer 1996; Podsakoff et al. 2000). Therefore, I propose the following:

Proposition 10: The greater the use of employee support routines to manage organizational suffering by facilitating the noticing, feeling, and responding to the suffering of others, the greater the organization's service quality.

The relationship between articulated interpretive schemes and service quality should strengthen when support routines are consistent with the articulated scheme. So, the relationship between espoused compassion and service quality should strengthen when support routines foster compassion. Therefore, I propose the following:

Proposition 11: The greater the use of employee support routines to manage organizational suffering by facilitating the noticing, feeling, and responding to the suffering of others, the stronger the positive relationship between espoused compassion and the organization's service quality.

2.6.6 Leadership Routines

Leadership routines have been well documented by organizational scholarship (see for a review Day 2000) as well as practitioner literatures (e.g. Kouzes and Posner 2007). A recent review discussed a wide variety of leadership routines performed by mid-level and senior leaders within organizations. Examples include feedback routines using 360-degree feedback, mentoring, and coaching actions to develop skills of subordinates in the workplace. Other examples include team leader coaching (Edmondson 2003) to increase speaking up or employee voice behaviors. In this study, I focus on ways that regular patterns of leadership actions routinize the expression of compassion and its

subprocesses. I focus on routine ways that leaders model compassion behaviors in the workplace, and regular ways that leaders create opportunities for noticing, empathizing, and responding to suffering.

Leadership routines that support the expression of compassion enable organizations to manage suffering through leader compassionate responding and legitimation of compassion behaviors. When these routines are used, it is more likely that leaders will notice suffering in the workplace because these routines structure opportunities for noticing pain. Awareness of suffering is a pre-condition for responding (Kanov et al. 2004). Routines that create opportunities for perspective taking increase the likelihood for empathetic concern (Davis 1983a, 1983b) and the likelihood of response. While these leadership routines may directly attend to workplace suffering, they also indirectly impact suffering. These routines serve as a model of how employees are expected to behave in the workplace. When leaders celebrate or show compassion, they legitimate compassion acts in the workplace and compassion becomes an expected behavior. This further attends to workplace suffering.

These routines should help manage suffering and enable employees to do better work. Better workplace performance should, in turn, affect service quality. This logic is similar to the service-profit chain logic (Heskett et al. 1994) whereby taking care of employees results in better customer service, which results in higher profit. Each process has the potential to positively impact subsequent acts or stages downstream in the service delivery process. Therefore, I propose the following:

Proposition 12: The greater the use of routine leadership practices to manage organizational suffering by facilitating the noticing, feeling, and responding to the suffering of others, the greater the organization's service quality.

The relationship between articulated interpretive schemes and service quality should strengthen when leadership routines are consistent with the articulated scheme.

The relationship between espoused compassion and service quality should strengthen when leadership routines facilitate compassion. Therefore, I propose the following:

Proposition 13: The greater the use of leadership practices to manage organizational suffering by facilitating the noticing, feeling, and responding to the suffering of others, the stronger the positive relationship between espoused compassion and the organization's service quality.

The subsequent chapter of this dissertation explores these relationships in greater depth. Chapter 3 provides an in-depth look at these compassion routines in a field study of two healthcare organizations. These data inform the development and validation of the compassion routines instrument. This chapter concludes with testable hypotheses based on these propositions and refined based on the empirical context and validated measures.

3 A STUDY OF COMPASSION ROUTINES: FIELD RESEARCH AND INSTRUMENT DEVELOPMENT AND VALIDATION

3.1 Introduction

With the exception of Dutton and colleagues case study (2006), I am unaware of any other research that explores compassion routines in depth. Prior to this research, I am also unaware of any study that describes a way to measure organizational structures that foster compassion. As a result, this study is needed to better understand the nature of these routines, and how to measure them. This chapter describes a two phase study that begins with a qualitative field study conducted to understand the nuanced nature of compassion routines in a hospital setting. Findings from the qualitative research are used to develop and validate a compassion routines measure. The findings of this chapter provide a framework for studying and measuring compassion routines. This chapter concludes with testable hypotheses that are based on the propositions developed in the previous chapter and the findings from this chapter.

3.2 Research Setting

Health services organizations are an appropriate context for this study given the nature of caregiving work and the suffering that employees experience on a regular basis. I focus on general acute care hospitals, in particular, for several reasons. First, hospitals are large scale organizations engaged in a high degree of service encounters and thus are an appropriate context for examining the relationship between routines and service quality. Second, hospitals deal with a significant amount of suffering of both patients and employees on a regular basis due to the acuity of care provided. Because hospitals deal

with a significant amount of pain due to their mission of treating the sick and dying, the work itself is emotionally toxic (Frost 2003, 2004). It can create a significant amount of suffering amongst employees who must deal with the emotional demands of caregiving on an everyday basis. In fact, healthcare organizations are known to have a high prevalence of and risk for burnout amongst employees (Leiter, Harvie, and Frizzell 1998; Maytum, Heiman, and Garwick 2004; AbuAlRub 2004; Payne 2001; Figley 1995; Mallett et al. 1991). Understanding the relationship between compassion routines, as a way of managing the costs of suffering and maintaining high quality of service, is important. Recent research from health services research supports this reasoning. Compassion positively relates to the quality of patient care (Stewart et al. 2000; Leiter, Harvie, and Frizzell 1998), clinical outcomes (Stewart et al. 2000; Fogarty et al. 1999), and patient satisfaction (Leiter, Harvie, and Frizzell 1998; Buller and Buller 1987). It is not surprising, then, that this industry is undergoing a movement towards a new way of humanistic caring evident in the rise of patient-centered care (Ponte et al. 2003; Stewart 2003; Stewart et al. 2000) and associated caregiving models such as Planetree© (Planetree 2011).

3.3 Phase 1: Field Study

This study focuses on understanding how organizations structure to support the expression of compassion not only towards patients and families, but also towards and amongst employees as well. This field study examines repeated ways of providing employee support, hiring employees, socializing them, rewarding them, communicating with them, supporting them, and leading them. These are common routines that take place on an everyday basis in all kinds of organizations. I look at these foundational

routines that scholars have examined in the past to see whether they can become vehicles for the expression of compassion—and if so, how these regularized ways of doing in organizations mitigate suffering. The study findings then inform the development of the compassion routines survey instrument. The field study consists of key informant interviews, non-participant observations, and the collection of archival data in order to better understand organizational routines. Two hospitals were selected in order to minimize variance of routines attributable to organizational characteristics (i.e. size, service offerings, profit status), but maximize on potential variation in compassion routines based on the extent that they espouse compassion (in their articulated schemes). A more detailed discussion of the field study's methods is provided below.

3.3.1 Methods

I conducted a qualitative field study at two acute care hospitals between December of 2009 and June of 2010 in order to study routines and their links to compassion and service in an industry well known for a high degree of organizational suffering. The field study included three forms of data collection: semi-structured interviews, non-participant observation, and archival data related to the types of routines or practice of compassion. I employed thematic analysis using an iterative process between coding data and reading organizational literature related to routines and compassion in order to better understand the nature of these aforementioned routines.

3.3.1.1 Sample

I use theoretical sampling (Glaser and Strauss 1967) to select two short-term non-federal acute care hospitals in the same metropolitan area of the southern United States

that provide similar medical service offerings and draw from the same patient and labor market pools. While displaying many similarities, these two organizations differ. One is not affiliated with a religion and does not espouse compassion as a core value in its mission statement. The other is Catholic and does espouse compassion in its mission statement. Because mission statements may be a reflection of the underlying ideologies of an organization, they may indicate the structures in use within an organization (Bartunek 1984; Ranson, Hinings, and Greenwood 1980). The purpose of this sampling strategy is to target organizations that are likely to have systematic differences in their organizational routines that facilitate compassion, but still provide similar services to a relatively similar patient population.

Alpha Hospital

Alpha hospital is one of the largest hospitals in its metropolitan area. It is a non-profit teaching hospital with no religious affiliation. Alpha is a part of an academic medical center; its physicians are appointed through the University's medical school. Alpha is a member of the academic medical center's regional health system that includes several other hospital entities in the state. This hospital operates more than five hundred acute care beds and is widely known for its extensive transplant services, cardiac care, neurological care, and cancer services. Alpha had been involved in a care transformation effort over the past two years in an effort to improve quality, teamwork, and make Alpha hospital care services more patient and family centered. This transformation effort is led by the Chief Medical and Quality Officer and the Chief Nursing Officer (CNO) for the health system. They are assisted by the Director of Care Transformation; he is also an ordained minister. Alpha is considered a prestigious and very formal institution, both of

which are reflected in its décor and dress. However, it is also viewed as the Goliath of its market after having acquired several other small and mid-size hospitals in the region in the past decade and re-branding them with the Alpha name.

Beta Hospital

Beta hospital is a large Catholic non-profit hospital located in the same metropolitan area as Alpha. The hospital was founded by a group of nuns, is the oldest in the city, and is owned by a large Catholic health system. Beta operates over 350 acute care beds and is also known for its cardiac care, oncology, and heart transplant services. Beta prides itself on its history and its “Spirit of Mercy.” Beta espouses its mission of mercy and compassion to both the community at large as well as to its employees. Many view the nuns who continue to work in the hospital as central to helping the hospital maintain its spirit of Mercy. These women are revered and loved by many employees. However, as the number of nuns continues to dwindle, many view the organization as changing and slipping away from its values. Beta has faced increasing financial pressures like many other hospitals in the U.S., and has suffered from lower patient volumes and lower reimbursements than some of its competitors. Beta is the only hospital in the state that accepts self-pay and Medicaid heart transplant patients. As the need and costs for such surgeries continue to rise, Beta is under greater financial strain to absorb significant expenses each time it performs a surgery for those types of patients. Beta began exploring long-term financial survival options that would allow it to retain its Catholic identity and mission. Beta recently attempted to form a joint operating agreement with a competitor health system in order to streamline much of its overhead and back office expenses. After multiple failed attempts to negotiate an agreement with two different health systems, Beta

has reached a preliminary agreement with a major health system in the market to form a joint operating agreement. As part of the agreement though, Beta relinquished its majority voting power.

3.3.1.2 Data

Semi-structured interviews:

Semi-structured interviews were conducted at both hospitals to gain a better understanding of the characteristics of the previously identified routines (e.g. employee support, leadership etc.). The interviews provided an opportunity to ask questions about the work routines listed above and focused on asking questions regarding the characteristics of each routine and how and to what extent such characteristics facilitate the subprocesses of compassion. (See Appendix I for the interview protocol).

Interviews ranged from twenty-six minutes to three hours and thirty-three minutes and averaged approximately an hour in length. A total of thirty-four interviews were conducted between Alpha and Beta. A total of twenty-eight hours and 15 minutes of audio recordings were collected from those participants who were willing to be audio recorded. All interviews were transcribed, resulting in 458 pages of single-spaced transcripts. All participants were contacted either via phone or email to participate, and all were asked to spend about 30 minutes with the interviewer. Most participants elected to spend longer than 30 minutes in the interview. Most of the interviews were conducted with management level employees ranging from senior executives such as the Chief Operating Officer and the Chief of Staff, to upper-level management directors for areas like Guest Services, Pastoral Care, and Food Services. In addition to front-line clinical managers, I also had an opportunity to speak with several frontline and support staff as

well. Per my agreement with Alpha, I conducted ten interviews with primarily senior-level executives and several lower-level staff members. The remaining 24 interviews were conducted at Beta. I ceased interviewing additional participants at Beta when theoretical saturation was reached, (i.e. no new information was gained from interviews) (Miles and Huberman 1994; Yin 2003). A list of all of the types of participants can be found in Appendix II. I also undertook non-participant observation of various hospital routines to enhance and complement interview data. This data form is described in detail below.

Non-participant observation:

Non-participant observation is a direct and passive observation of an event or events where the investigator does not participate in the event under study (Yin 2003). Non-participant observation is used for two primary reasons: (1) to become familiar with the organizations and (2) to observe the performance of any of these routines in order to better understand variation in the performance of these routines. I observed a variety of hospital routines in each hospital in order to better understand the nature of these compassion routines as well as supplement the interview data. (See Appendix III for the observation protocol, and Appendix IV for the locations of these observations).

Archival data:

I collected archival data from both organizations, when permissible, pertaining to the types of routines under study. I use this data to complement interview and observation data in order to better understand compassion routines and inform measure development. Examples of such data included hospital signage, marketing materials, employee newsletters, hospital communication emails, and screenshots of hospital intranet pages.

Other examples of collected archival data included interview guides, orientation packets, artwork, and findings from hospital administered surveys relating to employee satisfaction, understanding of organizational changes, and experience with certain departments such as pastoral care.

3.3.2 Field Research Analysis

All data were coded into categories using an iterative process in order to reflect common aspects of organizational routines that foster compassion. First, I coded the data for types of routines that were previously identified from the literature and how they support the expression of compassion. I documented these findings in a coding table (Miles and Huberman 1994) in order to describe the ostensive aspects of each routine that facilitated compassion subprocesses. I include in the table a narrative example from the transcripts as an illustration of a routine's ostensive characteristics. Next, I documented other organizational routines that supported the expression of compassion in the hospitals; these were routines not initially identified in Chapter 2 but field data suggested they, too, supported the expression of compassion. This coding table is located in Appendix V.

Evidence for a specific routine was denoted when (1) multiple transcripts from the same hospital discussed the routine, (2) at least one manager level transcript heavily discussed that the routine existed, or (3) at least one manager transcript from each hospital site discussed the routine. This method is intended to show general trends in the data. I discern common patterns of action that reflect a shared understanding of how the routine is enacted. Observation and archival data then supplemented most of these categories; this is noted for each category in the coding table. Routines were categorized

by the pre-determined theoretical routine categories—hiring, socialization, support, leadership, rewards, employee support, and communication. Routines that did not fit into these categories were analyzed and assigned an appropriate aggregate category or routine type. All types of routines are also noted in the coding table.

After coding the data, an expert panel of organizational theory, organizational compassion, and nursing scholars examined the table for face validity. Coding categories were eliminated or revised based on the panel's feedback (see Appendix V).

Finally, I then looked at the coded data to see patterns associated with hospital affiliation. Specifically, I looked for variation in the way in which a routine was discussed at each site. This allowed me to make inferences regarding how widely known a routine was or how legitimate it was perceived to be. I also looked for variation in language describing how often routines were enacted. This allowed me to make inferences regarding the extent to which a routine was regularly used. I also examined the language for variation in descriptions for who was involved in a routine's enactment. This allowed me to better understand the extensiveness of a routine's usage throughout an organization. I examined the patterns in the data in order to better understand whether routines were pervasive or if performances were enacted only in certain pockets within the hospital.

3.3.3 Field Research Findings

I am about to start rolling out some in-services to the critical care units and how they can avoid compassion fatigue and burnout. In a lot of ways for critical care units, when patients are there for a significant period of time, the staff develops relationships with those persons. In some ways a family kind of dynamic occurs. They begin to see those persons through the lens of their own loved ones. So when those persons die, staff is emotionally affected. I have, upon occasion, been called up to clinical areas after the 11th death in 30 days on the unit to do a de-briefing with staff, to find a way to ritualize their grief. It pulls on your heartstrings, and I think for most people who do this work, you can't come into healthcare and it doesn't impact you on some emotional level. (Alpha, Director of Staff Support)

Contextual Findings

Both field sites reveal significant demands placed on healthcare workers; this is consistent with previous research (Abendroth and Flannery 2006; AbuAlRub 2004; Leiter, Harvie, and Frizzell 1998; Maslach 1982; Maytum, Heiman, and Garwick 2004; Pfifferling and Gilley 2000). The field data reveal significant concerns for burnout and on-going stress related to business pressures, limited financial resources, regulations, and reimbursement issues that compromise care options and place strain on caregivers. Participants discuss feeling like they are frequently being pushed and pulled around cases where they are constrained by factors outside their control regarding the kind of care and discharge plans they can provide patients.

We have struggles around these cases and you even heard the angst from staff. They feel like they are pushed, we are pushovers. The fact they even feel that way, that they have that struggle, that's compassion right there. The fact that they struggle with it, that hospitals, hospitals don't have to. They can just say "No, it's not our responsibility, you are gone." If staff feel like they are a pushover, yeah that can go too far, but the fact is, it is struggle for them, and that is actually a good thing for our patients, and a good thing about our staff. (Beta, Director of Ethics)

Just as the work itself creates strain on healthcare workers, participants at both sites also discuss how personal suffering also impacts employee productivity. Employees bring their whole selves to work, even if they do not want to (Meyerson 1998), and personal issues can impact quality of care and performance. Healthcare work is a relatively low-wage industry, with many support staff members making just \$8-\$10/hr. Recent economic difficulties in this industry have further limited financial incentives for these workers. Qualitative data reflect this reality and multiple participants discussed financial problems that they or their colleagues have faced in recent years in light of

worsening economic conditions and financial cuts in their organizations. Challenges such as these continue to place great strain on healthcare workers. Such strain can negatively impact care in a variety of ways. Employees discussed how some either felt distracted from their work or how they tried to work extra shifts in order to make enough money, but at the expense of their own well-being (i.e. exhaustion).

Both Alpha and Beta were acutely aware of staff personal suffering and its associated risks. In fact, both human resource departments described how such suffering has increased during the recessionary period. This study revealed a variety of routines at Alpha and Beta that attempt to manage suffering through structure by fostering compassion. These compassion routines are described below. I begin with the routine types identified in Chapter 2 (see Appendix VI for a summary of all compassion routines documented in this study).

3.3.3.1 Employee Support Routines

Employee support routines are formalized and regular organizational ways of doing that are designed to aid employees by providing financial, emotional, and other instrumental assistance that goes beyond the traditional HR programs such as benefits, recognition programs, and training and development programs (Grant, Dutton, and Russo 2008). Some forms of training are also forms of employee support routines and are distinct from more traditional forms of training. These routines are more like interventions in response to unique circumstances related to crisis and stress events. What is common though to all of these routines is that they are repeated patterns of action that attempt to provide support to employees in order for employees to be able to perform better in their work. Routines attempt to address employee challenges related to personal

issues and workplace problems. Two categories of employee support routines emerged from the data: (1) employee emotional support and (2) hardship assistance. Each of these categories and their associated routines are described in greater detail below.

Employee Emotional Support

One of the most common ways that participants explained how the organization helped them either do their work or made their work life easier related to a variety of regular actions performed by members of the pastoral care department at each hospital. Participants described regular ways that pastoral care attempted to relieve staff of emotional burdens and personal suffering by providing emotional and spiritual support. Many participants remarked that these patterns of actions can significantly vary between hospitals they have worked for. For frontline medical staff, four routines—sitting with the dying, personal counseling, grief rituals, and support interventions, were widely discussed in interviews and in archival organizational surveys. Each routine is described in greater detail below.

Sitting with the Dying

Sitting with the Dying is a standard routine where pastoral care employees are available, on-site, 24 hours a day, for the purpose of being present at the time of death in order to provide emotional support to the patient and their families and fulfill administrative tasks when a patient dies. Tasks include calling the medical examiner and helping families arrange for the body to be transported to a funeral home. Medical staff at Beta described this role as crucial to the work they do because it relieves them of the emotional work demands (Hochschild 1983; Rafaeli and Sutton 1987; de Castro 2004) during a patient death and allows these clinicians to preserve the energies needed to

continue to care for their other patients. This is evident in comments such as one by a Beta RN who described pastoral care members as “taking care of the family during difficult times or during a crisis, [this] allows us to focus our attention and energy on the patient.”

Transcripts and surveys reveal that many Beta staff members described how important it is for someone from the hospital to be “present in the moment” at the time of death to help the patient and grieving families because the emotional and spiritual needs increase as death or a patient crisis (i.e. coding) transpires. From interview transcripts and archival data, staff at Alpha and Beta revealed that this practice can widely vary between hospitals generally speaking, especially with respect to coverage and availability. Many staff members reported that it is common for hospitals to have pastoral care employees on-call and available via phone around the clock, but that this is not the same as having someone available on site at all times to be physically present. Because a patient’s health can quickly decline, these crises require not only an immediate clinical response, but they often require an immediate need for emotional support as well. When pastoral care is not available, or when a physical presence is more appropriate, that burden falls on the frontline caregiver who is attempting to also care for their other (living) patients.

Participants describe this burden:

I think being overloaded prevents compassion, when you have too much to do that you don't have time to really sit, and listen, and be there for patients when you need to be because you have too many other things pulling on you. (Alpha, RN and Nursing Unit Director)

The *Sitting with the Dying* routine provides support to frontline staff by transferring the taxing burdens of emotional labor from the caregiver to the chaplains. It helps preserve caregiver energy needed to focus on the technical aspects of care for all

patients as well as the on-going emotional needs of other patients and families not presently in crisis. When pastoral care staff enact the *Sitting with the Dying* routine, they act as toxin handlers (Frost 2003, 2004); they minimize compassion fatigue at the frontline by shifting the burden of emotional labor at the bedside away from the caregiver. Many staff members discussed how much they valued this routine:

As an RN, I acutely recognize the tremendous job they do and the enormity of the load they shoulder for us...they are awesome. (Beta RN)

This routine serves multiple purposes. Not only does it help manage frontline staff's emotional demands, it also structures to provide compassion to patients/families in crisis as well.

Personal Support and Counseling

Both Alpha and Beta had counseling assistance available through their employee assistance programs, which is a kind of employee support routine. At Beta, pastoral care employees also regularly counseled staff in ways that addressed their emotional and spiritual needs. Beta staff tended to use pastoral care for emotional/spiritual support not only related to a difficult code or the death of a patient, but also for receiving support for issues related to their own lives.

He has been there for me. Before and after I lost my mom, he even talked with her on the phone and she lived in another state. (Beta caregiver)

Regularly seeking help from pastoral care for personal support is a means by which employees seek to relieve their own pain and suffering as they deal with both work and personal issues. Help seeking enables employees to feel better and be able to perform their work. The regular use of pastoral care members to provide this kind of support to employees seeking their help is a routine way that the organization structures to provide

such support. At Alpha, the director and assistant director of staff support are both ordained ministers. Their official role in the organization is to provide personal support to staff. This is similar to the support work done by the general pastoral care program at Beta. By creating a staff support department at the hospital, Alpha also structured a way to help respond to the suffering of its employees.

Grief Rituals

Another employee emotional support routine is the grief ritual. Healthcare workers experience loss on a daily basis. Most often it is a result of the loss of a patient, but in some instances it is experienced as the loss of a co-worker or loved one. Many participants from both hospitals describe how members of the hospital regularly facilitated grief rituals such as memorial services for colleagues, their loved ones, or for patients with whom staff had developed a close relationship. By facilitating such rituals, each organization attempted to help employees deal with their grief. These grief enactments were more often spiritual in nature, and were in response to employee grief, a kind of employee suffering.

I am also responsible for facilitating rituals. I call them rituals, for staff, particularly if there is a death of a staff person—inviting their colleagues to find a way to grieve the death of that colleague. (Alpha, Director of Staff Support, Ordained Minister)

At Beta, pastoral care often facilitated these memorials. Multiple participants discussed how, in addition to memorial facilitators (i.e. chaplains, nuns), Beta employees also participated in the routine by sharing their musical talents as part of the memorial service.

If I lose a staff, their children or whoever will be invited in to go to the memorial service here, had a very pretty service up in the chapel for one of our cafeteria ladies who passed away. She had been sick, she got on disability, but another department had a pianist who plays beautifully and he sings and he came and

gave his time, do a couple songs and play here in the service, so you know we all work together. (Beta, Director of Food Services)

Both interview and observation data from Beta support the notion of not only Pastoral Care employees facilitating these rituals, but of a collective effort by many employees to perform these grief rituals. This is evident in Beta Food Services Director's description of "working together" in the ritual's enactment.

Support Interventions

Support interventions are another kind of employee support routine, and this routine differs from traditional HR training programs such as orientation or courses related to workplace skills. Support interventions consist of repeated patterns of action that provide customized relief to groups of employees in response to a specific crisis event that is adversely affecting the group and its members. Both Alpha and Beta enacted this routine, and these interventions were also used as a form of organizational learning (Argyris and Schon 1978; Edmondson 1999). Employees viewed these sessions as opportunities to vent, but they also created structured opportunities to learn from difficult events in order to provide better care in the future. Alpha and Beta utilized different roles to perform these functions. In Alpha, the non-religious hospital, the majority of this work was performed by the Director of Staff Support who was an ordained minister.

We have crisis moment training, so we go into a department that has had a crisis that's occurred, and we know that the staff, it's very emotionally difficult, but we still need to deliver care and move forward. So, we do a lot of training in the moment..." (Alpha, Director of Staff Support)

At Beta, the Catholic hospital, much of the responsibilities for performing such crisis interventions were assigned to its Director of Ethics, who had significant training in

Catholic theology but often relied on his ethics and mediation training when performing this routine.

I do what they call a lunch and learn on a specific unit that has had a lot of angst. I'll go back to the unit as a follow up, usually as an education piece to it. They need to be heard, but in a lot of cases they need to consider other facts and learn some things too, so it's an opportunity to talk, sit down and talk and discuss.”
(Beta, Ethics Director)

In addition, Beta recently launched *Schwartz Center Rounds*© (Schwartz Center 2011) which is a support intervention routine used to manage frontline staff compassion fatigue and stress in response to a singular event. The routine is performed monthly, and each event is structured around a recent and particularly difficult case. Beta's program was created and managed by its Director of Palliative Care, a physician.

The whole goal of the Rounds is to help support caregivers to maintain compassion in their care...the whole point is to talk about the non-clinical aspects of a difficult case in order to support each other. Because, I mean, you can have compassion burnout, unless you come up with ways to support it and so this is an opportunity to allow people to come in and support each other and vent quite honestly. (Beta, Director of Ethics)

The use of the support intervention routine at both Alpha and Beta reveal ways that each organization structures an opportunity for noticing the suffering and pain associated with crisis events for the clinical staff. The support intervention routine, such as the *Schwartz Center Rounds*© enactment, is a regularized way to intervene and relieve suffering (i.e. burnout, compassion fatigue) of staff in a way that is geared to the specific crisis.

Hardship Assistance

In addition to employee emotional support routines, hardship assistance routines were another kind of employee support routine studied at each organization. These are

repeated patterns of action designed to provide tangible forms of assistance to employees facing hardship. This routine type is noteworthy not only for its charitable assistance, but also because it creates opportunities for compassionate responding by fellow employees. Some organizations that have such programs, like Alpha and Beta, have developed routine ways to allow employees to give towards funding these programs that benefit their co-workers. This type of routine is becoming more and more common as evidenced in other research describing its enactment in organizations such as hospitals (Lilius et al. 2008), as well as a variety of other companies like Southwest Airlines (Pfeffer 2006), Domino's Pizza, and The Limited (Grant, Dutton, and Russo 2008). This routine provides financial assistance, tangible forms of assistance (i.e. goods, services), or paid-time off assistance to employees facing hardship. In fact, both hospitals had a routine in place that provided financial assistance to employees. Alpha and Beta employees contributed to these employee hardship funds through payroll deductions. Alpha provided grants from their program and Beta's program was a no-interest loan program. Beta also provided, in response to unique hardship events such as recent flooding and the Haiti earthquake, grants and leave time from its *Foundation* rather than through its hardship loans.

In addition to financial assistance, both hospitals also used a vacation donation program. This program allows employees to donate earned paid-time off to a general hardship vacation banking program or directly to a specific individual who is dealing with personal hardships and needs additional leave time.

I've had one girl donate eighty hours of vacation time, to a person who had lost the limb, because she knew she needed it." (Beta, Director of Food Services)

Charitable giving is another example of this routine; it often occurred during holidays. Both hospitals engaged in "Christmas giving." Many employees described how

employees from the hospital were identified as in need of assistance. Departments and units banded together to coordinate resources and directly provide for these employees and their families through targeted philanthropic giving efforts during the holiday season.

Every Christmas, our staff can sponsor a family. If I've got a staff member that needs help at Christmas time, which I did because I had an employee that had medical problems and she was out of work and so, she was one of the families that got a gift you know, got sponsored at Christmas time, that's compassion. (Beta Director of Food Services)

Hardship routine enactment facilitates the subprocesses of compassion in several ways. First, these routinized actions provide an opportunity to respond to the suffering of others. The routine's existence establishes the precedent of noticing the suffering of fellow employees. When employees are allowed to donate money, resources, or earned time off to help a colleague, it legitimates that act of giving and thus creates an expectation to notice when fellow employees are in need. In so doing, it encourages and prosocially motivates employees to give back (Grant, Dutton, and Russo 2008), a kind of compassionate responding. Both Alpha and Beta relied on a variety of ways in which to provide support to employees.

3.3.3.2 Leadership Routines

Leadership routines are repeated patterns of leadership actions performed by leaders within an organization that scholars have a long history of documenting (for a review see Day 2000). Leaders refers to those who manage others, and this includes supervisors, middle management, and senior administration. This field study focuses on routines that either facilitate leaders noticing the suffering of employees, or that create opportunities for empathetic concern for employees. These routines are unique in that in order for leaders to attempt to manage problems like burnout, they must first be able to

notice them. Shadowing and feedback routines were two specific types of leadership routines that were supported in the data records that facilitated these subprocesses of compassion.

Shadowing

Shadowing is a pattern of actions performed on a regular basis by managers and executives in an organization. Leaders work or walk alongside with employees during their shifts. This routine allows leaders to gain perspective and understanding of the actual work their employees perform by doing it themselves. Leaders experience and hear the problems and challenges employees face on a regular basis. Through shadowing, leaders create opportunities for empathetic concern as a result of a deepened understanding of the struggles their employees face on a regular basis.

Last Friday, I cleaned rooms with a housekeeper up on 5-West...I do this once a month, spend a day with the housekeepers (Beta Director of Environmental Services)

I schedule time, I already mentioned, I scheduled time to be out there, like I am going to be working in the infusion center in a couple weeks for a shift. I am going to put scrubs on and shadow someone all day.” (Alpha, Director of Care Transformation)

Both organizations had some leaders, mostly middle managers and directors, who regularly engaged in shadowing on a more informal basis.

Feedback

This routine is similar to shadowing; it structures an opportunity for leaders to notice problems or concerns in the workplace. This kind of routine takes multiple forms such as scheduled feedback forums with senior leadership or more intimate practices such as inviting staff to have lunch with a senior executive so that administration can better

understand “what’s really happening.” This routine was mentioned at both organizations, with examples such as the following:

Our CEO has a monthly luncheon where a random selection of 20 people are invited to come, and lunch, sandwich lunch. And he asks the questions, “what’s going on, what’s the gossip around here, tell me what the deal is, tell me what needs to happen! And he is just open for feedback.” (Alpha Administrative Assistant)

Alpha participants also discussed a regular practice at their downtown location of not scheduling any meetings on a specific afternoon each week so that leaders could be available to round on floors in order to receive feedback from staff. This routine structures an opportunity to be present and notice. At Beta, participants also discussed feedback routines by drawing attention to the absence or lack of performance of these routines by senior administration. A majority of directors and managers that participated in the study described Beta senior administration as failing to enact feedback routines on a regular basis.

I feel like our senior administration, it’s been shown on our employee satisfaction surveys, they even know it, I think they struggle with how to, but they are perceived to be very distant, and physically too by the way. They moved to a different building basically. We don’t see them... for the most part we have a lot of administrators that don’t spend too much time understanding what goes on here every day operationally.” (Beta Department Director)

3.3.3.3 Hiring Routines

These are routines that relate to the hiring process, and are repeated ways that the hospital screens applicants for fit (Kristof 1996), generally speaking, but in particular for the likelihood that applicants will show compassion in the workplace, be supportive of its expression, and/or model compassion behaviors on the job. Both Alpha and Beta enacted variations of this hiring routine.

Behavioral Interviewing

One kind of hiring routine involves the repeated use of behavioral interviewing questions to assess the likelihood that an applicant will show compassion at work.

We do behavioral based questions like “tell me about a time when you had somebody you felt like really needed somebody to listen and what you did to make them feel like somebody was. (Beta, Support Department Director)

What we look for in those answers is the giving of themselves and warmth and understanding and the empathy, we look for those qualities in their answers. (Alpha, Chief Nursing Officer)

Participants’ descriptions of these interview questions relate to noticing suffering, empathizing with others, and taking action to help alleviate suffering (e.g. listening, prosocial helping, or providing resources, etc.).

Promote Culture of Caring

Similarly, participants also discuss how hiring routines are used to assess employee fit or alignment with the organization’s mission or philosophy during the interview process by promoting a culture of caring or mercy. At Beta, multiple participants describe assessing fit or familiarity with the organization’s Mercy mission when they discuss the organization’s values with interviewees.

I talk about the Beta philosophy, what we’re about here, how we treat each other, and that’s what’s expected. I’ll tell them, “if that’s not for you, please find another position, if that’s not true, if that’s not your cup of tea, then this is not the right place for you.” (Beta manager)

Both compassion and mercy are values that are a part of Beta’s publicized mission. As part of the hiring routine, they regularly discuss how the philosophy or mission is a part of how people are expected to behave at work. Although Alpha does not espouse compassion as part of its mission, directors and managers did discuss the importance of hiring employees who wanted to work at Alpha “for the right reasons,” or because “their

hearts are in the right place.” Human resource personnel from both organizations discussed trying to assess why applicants want to work at either hospital—is it for the money, a job orientation, or is it because of the organization’s purpose of caring? The latter reflects more of a calling orientation towards work (Wrzesniewski and Dutton 2001). HR personnel also mentioned how assessing applicants’ motivations help them determine cultural fit and likelihood that applicants will show compassion, empathy, or caring in the workplace.

3.3.3.4 Socialization Routines

Once organizations hire new employees, they engage in socialization acts to encourage and remind both new and existing members of the organizations to engage in valued behaviors. As part of this field study, I saw evidence of ways in which both organizations used socialization routines to foster compassion in the workplace. Both Alpha and Beta used orientation training as well as on-the-job training programs in order to promote valued behaviors. Multiple Beta participants discussed the importance of promoting and modeling compassion on the job and during training efforts. Several routines were used that were either vehicles for compassion subprocesses, or could become vehicles for supporting the expression of compassion at work. These routines, *Perspective Taking* and *Mission and Values Monitoring*, are described in greater detail below.

Perspective Taking

One kind of socialization routine that fosters compassion involves perspective taking. Perspective taking is a cognitive process in which individuals try to understand others’ needs and viewpoints (Sharon and Axtell 2001; Axtell 2007; Grant and Berry

2011). At Beta, multiple participants spoke about the importance of showing compassion and mercy to patients, families, and colleagues. Beta regularly encouraged and reminded members to engage in “perspective taking.” Beta members described this routine as a means to better understand the kind of suffering their colleagues, patients, or family members were experiencing in order to help staff better understand how they could provide better service and alleviate pain. Alpha also encouraged perspective taking during their mandatory orientation.

Alpha Healthcare with 10-12,000 employees in a dozen different zip codes has great potential of being cool, aloof, and impersonal. I say we cannot tolerate that, and then I usually ask, “How many people have been hospitalized?” And about half the hands usually go up. So we talk about that experience and we talk about the value of caring. (Alpha COO).

Like Alpha, Beta’s director of hospitality asks new hires in the orientation program to put themselves in the position of those they serve. He uses the exercise to encourage empathy in order to best understand and respond to the needs of others.

So I ask them, “You have to have a time when you felt vulnerable, take yourself back to that time when you felt like you had no control over anything. Remember that every time you have an interaction with a patient; that is probably what they are feeling like or even more so.” (Beta, Director of Hospitality and Guest Services)

At Beta, the orientation is only one of many forums where the perspective taking routine is encouraged. Multiple directors discussed the routine as being a regular but informal part of managing and training their staff. Although participants describe that the routine was frequently enacted, leaders tended to emphasize taking the perspective of patients/family members more so than of other co-workers. Similarly, when asking non-management staff about this, they understood this routine to primarily relate to perspective taking of patients and family members rather than of their peers.

I think of the patient as ‘that’s my family member.’ You have to take care of that patient, and you have to want that patient be treated like #1, just like they would want their family member to be treated. (Beta, Transporter)

Like descriptions of the frequency of a routine’s enactment, the target of the perspective taking routine may be another way in which healthcare organizations vary in the extent to which they notice and respond to the suffering of employees.

At Alpha, the organization was in the process of building up a patient-family advisor training program, which is a characteristic of patient-centered care (Ponte et al. 2003). As part of its care transformation, Alpha was attempting to integrate more patient-centered care practices, one of which is patient-family advising. Patient-family advising involves patients or their family members helping train staff. Patients/family members apply or are nominated to become an advisor and they go through hospital training. These advisors bring their perspectives as patients and family members to help educate staff on the needs of patients and families. They provide a more comprehensive understanding of patient and family’s suffering in order to allow caregivers to improve care. By structuring training to foster perspective taking, this routine creates opportunities for empathetic concern and compassionate responding.

Mission and Values Monitoring

This routine reminds employees of the importance of the hospital’s mission. It is also used to monitor and reflect upon actions in order to ensure that they are consistent with the organization’s mission and goals. At Alpha, the hospital stressed excellence in care and patient-centeredness. For Beta, mercy and compassion are a central component to Beta’s mission. At Alpha, monitoring was most often enacted by the Care

Transformation Office in conjunction with the Human Resource Department and Chief Medical Officer's office. Initiatives, new programs, and training were vetted to ensure they were consistent with their recently implemented care transformation model based on a patient-centered care (PCC) philosophy. Participants discussed how senior management reflected on whether initiatives were consistent with the espoused values in the care transformation plan. Although compassion was not an espoused value, such PCC routine enactments reveal ways that a socialization routine could be enacted in organizations that value compassion.

At Beta, the organization had a mission effectiveness committee that met monthly in order to review proposed initiatives and efforts to ensure they were consistent and in alignment with the hospital's Mercy mission. Major changes such as layoffs, updating retirement plans, and adding additional medical services (e.g. concierge medicine), were all discussed in these meetings. The committee consisted of senior leaders from the different areas of management, pastoral care, and the Sisters. The committee was headed by the Chief Mission officer. Similar to the mission effectiveness meetings, similar micro reflections were regularly incorporated into other meetings across the hospital. Members described how members publicly read the hospital's mission or reflected upon how a meeting's topic fit with the hospital's mission as a way to monitor consistency between what it espoused and its actions. Similarly, leaders described how a blessing was often incorporated into the start or conclusion of a meeting as a way to remind attendees of the mission of the organization and ensure that discussions aligned with the mission.

3.3.3.5 *Reward Routines*

Organizations use reward routines to recognize employees for demonstrating valued behaviors or for achieving outcomes that align well with the mission or goals of an organization. The field study looked at these kinds of routines and found evidence for ways in which reward routines support the expression of compassion. This type of routine involves ways that the organization and its leaders recognize and celebrate acts of compassion and helping towards patients, family members, and co-workers.

Recognition Cards

Charles is a nurse down in the ER and he has been here for many years. Charles is a very quiet, industrious, behind the scenes kind of guy. We had a mason die down in the ER. It was pouring down rain, I will never forget this... I was working with the family, taking care of the things that needed to be taken care of and I looked down the hallway where the helipad is and Charles was outside in the pouring down rain and was cutting off with his nursing scissors a piece of greenery off of a bush. As it turns out he learned it is important to the masons that their loved one go wherever they go with a piece of greenery, the deceased go with a piece of greenery. So in the rain, Charles went out to snip a piece of greenery to provide them with that which they needed most. I sent him an angel card, and that was my way of affirming him with something tangible. I spoke to him, I thanked him, I affirmed him in the moment of that, and then I sent an angel card to his director, manager.

Recognition cards were used at both Alpha and Beta as a routine way to recognize acts of compassion. Beta utilized “Angel Cards” that members, patients, and family members could fill out on behalf of any Beta member who demonstrated high quality care, compassion, mercy, or helping. These cards were publicly available throughout the hospital and prominently displayed on wall holders. Card writers select, from a list on the card, which of Beta’s values were demonstrated by the recipient. Compassion and mercy are listed values. The card also requires a written description of the demonstrated action. These cards are then submitted to HR, electronically recorded, and distributed to the

recipient's manager. Cards are then shared with the employee, either in a department meeting or one-on-one. Beta participants often remarked that they served as a reminder that compassion was expected and rewarded as well.

At Alpha, transcripts suggest that publicly displayed comment cards were infrequently used and difficult to locate. Most were submitted by patients or family members to recognize frontline caregivers. Nursing staff describe that family and patients often requested a card in order to provide feedback. Participants were often unable to describe a standard way of recording submitted cards, and many were unsure if the cards were still "officially in use." Leaders varied in whether or not these comment cards were publicized, celebrated, or the scale of the celebration.

Awards

Alpha and Beta both utilize compassion award programs as a formal medium for recognizing compassionate behavior at work. For Alpha, the award is limited to nursing, volunteers, and guest services. For example, Alpha participates in the national Daisy Award program to recognize compassionate caregiving (Daisy Foundation 2011), for which RNs are eligible. Beta has multiple award programs to recognize a variety of roles within the organization that demonstrate compassion. The hospital distributes formal awards either monthly or annually to each of the following stakeholder groups—support staff (non-management), management, physicians, nursing and frontline caregivers, and volunteers. They also have an organization-wide award program to recognize any one individual who best exemplifies the values of the hospital. Each of these award programs is well-known and well-regarded; they were also mentioned in multiple interviews. One

of the programs, the Sister O’Hara² award, is given monthly to staff, and the ceremony was observed as part of the study. In this celebration, one individual is recognized by executive leaders in a hospital-wide ceremony in the auditorium. Other hospital members participate in the ceremony through speeches, singing, and playing musical instruments to celebrate this person’s commitment to the organization’s “Mercy mission.”

3.3.3.6 Communication Routines

Communication routines are common and repeated patterns of communicative actions (genres) that organizations engage in to disseminate information to employees using a variety of organizational media (Feldman 2000; Yates and Orlikowski 1992). This study examined communication routines that consist of repeated use of hospital communication media to promote, encourage, or celebrate compassion. Common genres included the hospital newsletter in which compassion stories were shared. Similarly, compassion imagery was displayed through the use of photographs of members engaged in compassion acts on bulletin boards, display cases, and other display outlets. Beta promoted compassion and mercy behaviors through the regular display of the words—compassion and mercy, in hospital signage including banners, billboards, bookmarks and other media of symbolic communication (Swidler 1986) (see Figure 5 for example).

[Insert Figure 5 Here]

3.3.3.7 Additional Routines

In addition to routines that were theoretically selected for study, field data revealed other types of routines that also supported the expression of compassion. These routines are described in further detail below.

² Name changed to protect identity of organization

Spiritual Reminders

Data suggest that spiritual routines were performed on a regular basis that drew attention to the spiritual needs of others as a result of personal suffering. At Beta, this routine functioned as a kind of regular reminder of the hospital's spiritual mission of attending to one's own spiritual needs and the spiritual needs of others.

Enactments of this routine included twice daily non-denominational intercom prayers, a daily mass in the chapel, department blessings performed by pastoral care, and blessings or prayers performed by the nuns/pastoral care at the start of business meetings. By incorporating these very micro routines into the everyday life at Beta, Beta participants often remarked that these routines, such as "the evening prayer, just sets the tone no matter how busy the night...and brings peace and calm (Beta night shift staff member)." These enactments were also viewed as "relieving the patient's hardship and staff's stress," according to one Beta clinician. This sentiment was echoed by many Beta employees.

What is particularly interesting about these routines is that many of Beta's employees are not Catholic but nevertheless expressed valuing these spiritual enactments that reminded them of the importance of mercy and compassion, and the spiritual needs of others and themselves. In fact, Beta's chief of staff discussed his surprise when reviewing recent survey results which demonstrated that doctors valued the Catholic mission and its associated practices.

I expected to see a lot of them don't give a damn. The hospital doctors were actually saying yes, it's important. You know what, most are not Catholic, I mean, there are a lot of Jewish doctors and a lot of everything else, and this to me was a surprise!

By performing these spiritual reminders on a regular basis, Beta routinely drew attention to the expectation of mercy and compassion, and attention to suffering of its employees. In so doing, the routines legitimate and encourage compassion at work.

Patient Care Routines

Although the design of this research study focused primarily on understanding how routines support the expression of compassion in the workplace, this study anticipated that participants would also share ways in which the hospital fostered compassion subprocesses towards patients and their families as well. As such, there were several types of patient care routines I observed that supported the expression of compassion. These routines are discussed below.

Financial Assistance for Patients/Families

Like the *Hardship* routine discussed earlier, participants described ways the hospital attempts to alleviate some of the suffering or hardship associated with a loved one's stay. Both hospitals had resources available on-site to help patients and family members fill out the paperwork to sign up for Medicaid or receive other financial assistance to pay for the medical bills.

Well we have a beautiful financial assistance program and they're very compassionate people, and as soon as we hear that there might be a financial situation, we get them involved, so we get that going quickly so they can get down to that room, get that necessary paperwork so that anxiety goes away, with that patient thinking I might be eligible for the "Smith" Foundation to pay for my heart surgery or there might be some type of other foundation that there's monies that can help me with this apparatus that I need, so they're very valuable. (Beta, Patient Advocate)

Participants also talked about more direct, smaller-scale forms of assistance available to family members who incurred financial hardship as a result of their loved one's stay.

Such assistance helped cover expenses related to meals, lodging, and parking. Common manifestations of this routine included providing parking vouchers, parking discounts, lodging discounts and cafeteria vouchers to families in need. Both organizations utilized their guest services/hospitality group to manage this routine. They worked with frontline caregivers to inform them of the availability of such resources, to encourage them to pay attention to signs indicating that certain families needed assistance, and to show them how to contact the appropriate people in order to ensure these resources were made available to families experiencing financial hardship.

I had a woman referred to me, her husband has been here for 9 days and they came to the emergency room, she parked her car, and she hasn't left. She has stayed here in this hospital every single minute, so when she realized that it was going to be \$5.00 a day, she doesn't have that money, and she's come down here from a small town and they had nothing. So, I was able to get some meal vouchers and I was able to get her some help with the parking too. (Beta, Director Patient Advocacy)

Palliative Care

At Beta hospital, multiple participants mentioned the recent creation of a palliative care program to regularly manage pain and end of life issues throughout a patient's disease process. The existence and enactment of a palliative care routine differs from more traditional clinical care routines. Palliative care is a sub-specialty that focuses on symptom, pain, and stress management from serious illness in order to help improve quality of life and attend to patient suffering (Mahon 2010). Discussions with caregivers at both Alpha and Beta suggest that palliative care is not necessarily widely available at all hospitals. In fact, only 60 percent of hospitals in the U.S. have such programs (Center to Advance Palliative Care 2010), and yet scholars and practitioners alike recognize that pain and suffering are part of the disease management or treatment process (i.e.

chemotherapy treatment). In establishing and using such a routine, hospitals attempt to provide a more holistic way of caring for their patients. This routine incorporates all three compassion subprocesses—noticing suffering, empathy towards patients and their families during the disease process, and palliative care actions to manage suffering (see Center to Advance Palliative Care 2010; Lo, Quill, and Tulsky 1999).

Nevertheless, the enactment of such a routine is not a simple choice based on mission or ethical principles, but rather one of resource allocation and financial viability. Like all other forms of care, palliative care requires trained and licensed staff and physicians. While other forms of medical treatment are often times reimbursed under most insurance plans, poor reimbursement and lack of institutional resources are the primary barriers to palliative care (Hui et al. 2010). As such, participants recognized that it is often the patient-mix, the makeup of patients and their associated insurance plan coverage, which dictate the financial feasibility of palliative care rather than the mission or goals of the hospital. More simply put by the Chief Operating Officer (COO) of Alpha, “no margin, no mission.”

Bedside Shift Reporting

Another patient care routine includes shift change reporting (Anderson and Mangino 2006; Chaboyer et al. 2009). Scholars and practitioners advocate for the need for face-to-face contact during shift change reporting (Chaboyer et al. 2009; Rutherford, Lee, and Greiner 2004). Shift change reporting is the process by which a nurse currently on duty provides a detailed report of the current status of all of her patients at the end of her shift to the nurse who is coming on duty to relieve her. Hospitals have a variety of ways to document these shift change reports such as documenting on patient charts,

through shift reporting phone or IT systems, or through face-to-face reporting, including at the bedside. At Alpha, they were in the process of training all of their staff to provide bedside shift change reporting, reporting that is a face-to-face process in the presence of the patient. This routine structures a way to create opportunities for noticing patient suffering that might otherwise not be noticed as quickly if the nurses performed shift change reporting outside of the patient's room. Enactment of bedside shift change reporting structures a routine way for nurses to notice patient distress, or a change in condition that would not otherwise be immediately detected in the absence of direct patient contact.

While Alpha participant transcripts clearly provided evidence of noticing opportunities during bedside shift reporting, transcripts at Alpha reveal that the way that nurses understood this routine related less to compassion. Instead, participants understood the routine as being patient-centered because it increases the patient's involvement in his care (Anderson and Mangino 2006), and reduces medical errors (Chaboyer et al. 2009). As such, it was less apparent that they recognized that such a routine creates opportunities for noticing suffering and compassionate responding.

3.3.4 Field Research Discussion

Both Alpha and Beta engaged in a variety of compassion routines. However, when comparing the data between hospitals, it becomes evident that the ways in which these routines were in use varied. These differences are described in greater detail below.

Employee Support

The extent to which employee support routines were in use at each hospital varied. Both Alpha and Beta had a "Sitting with the Dying Routine." Someone from

pastoral care or staff support was always on-call and available should frontline caregivers need help in this moment of crisis. In interviews with Alpha members, data suggest that this routine is infrequently enacted. Transcript data suggest there is a somewhat unspoken understanding at Alpha that caregivers do not feel it is appropriate to seek that kind of help for themselves, but rather it is only appropriate when the sought help is only for patients and family members. This suggests that the routine is less legitimate at Alpha.

The pastoral services office just did a grand round on working with complicated patients and families. We focused primarily on the patient, but we left staff with resources, so when you have a complicated situation that is pulling on you, and creating stress on you and the team, here are the resources that are available for you to contact. They can call on the chaplain 24/7/365 days a year. The question is, are people using them? So, when they have issues, don't be afraid to talk about them, you can find creative ways to resolve them versus waiting until they get to crisis levels and then everything falls apart. (Alpha, Chaplain)

However, at Beta, caregivers refer to pastoral care as the “heart” and “the backbone” of the organization. Most frontline caregivers stressed the importance of pastoral care being available during a patient crisis. Language from Beta caregivers includes statements such as “I couldn’t do my job without them.” This suggests that the *Sitting with the Dying* routine is deeply embedded at Beta; that it is a legitimate and regularly enacted routine. The *Personal Support and Counseling* routine at Alpha and Beta reflects similar patterns of enactment and pervasiveness between organizations. Both hospitals have this routine, but differ in the extent to which data suggests that employees utilized the routine. Transcripts and archival data reveal that Beta staff regularly spoke to members of pastoral care and *Sister Iris*³ to discuss personal problems. In fact, it was through this routine that the organization often became aware of

³ Name changed of participant

employee suffering. This routine provided an opportunity for noticing suffering and also provided information needed to customize a compassionate response to employees in need. However, at Alpha, transcripts reveal that this routine is less legitimate.

They have their own set of emotional issues, spiritual issues. I do really strongly encourage staff, if you have issues, come down, it's a confidential space. But, a lot of folk were afraid to say that they needed help because that then might be used against them. Staff support has been around for a long time here, people are becoming more comfortable saying "let's figure out a way to talk this out."
(Alpha, Dir. Staff Support)

Alpha's director states that employees seem afraid to enact the routine. Such language suggests that while the routine exists, the routine has less legitimacy than its similar enactment at Beta. This difference also suggests that workplace suffering of employees was more widely recognized as a common occurrence in the workplace at Beta than at Alpha. At Beta, transcripts reveal evidence that it was considered more normal and appropriate to utilize the routine in order to help manage suffering.

Another way in which Alpha and Beta varied was in the extent to which employees engaged in the *Grief Ritual* routine. Both organizations utilized members of pastoral care to facilitate this routine. However, Beta invited employees to contribute their talents in a more collective ritual of prayer and song, and they did. Another difference in employee support routines between the two hospitals is seen in the kind of support provided. At Alpha, the nature of support was primarily tangible. Grant money and donated vacation days were provided to employees facing hardship. At Beta, however, transcripts suggest that both tangible and intangible support were regularly provided. Intangible support related to psychological, emotional, and spiritual needs of employees and hospital members in addition to tangible support which was financial.

This suggests that Alpha's template for its employee support routines was primarily focused on tangible assistance, whereas at Beta, employees drew upon a template that allowed for more varied forms of assistance—tangible and intangible responses. See figure 6 for a comparison between Alpha and Beta (see Figure 6).

[Insert Figure 6 Here]

Leadership Routines

Both Alpha and Beta had leadership routines that supported the expression of compassion—feedback and shadowing. However, Beta had more variation in the ways these routine types were enacted. For example, Beta had a formal shadowing program, “Rounds,” for its executive team, whereas Alpha did not. Beta enacted both the formal Rounds routine, as well as an informal shadowing routine. Despite having a formal “Rounds” routine, few executives performed the routine.

I've actually got carts together for them to do the rounding but then it's the same people who do the rounding, and they have to be forced to do things. I mean I've had to organize these things and I couldn't even get people to commit to it where... I hear “well I'm out of town this weekend” and “I'm doing this and blah, blah, blah” and you know you just have the same people signing up for it. And then there's like no repercussions sometimes I think for those who don't. (Beta, HR staff member)

Multiple Beta participants mentioned that staff was aware of the formal Rounds routine. They also described how administration rarely performed the routine. Participants often described the senior leadership team as distant and unfamiliar with the challenges that employees faced on a daily basis. They used the Rounds routine as an example to illustrate this perception of senior administration. This is evident in the comment below:

We don't see them. Every now and then you get a nursing director that rounds every day, and she is fantastic, and she gets it. But for the most part we have a lot of administrators that don't spend too much time understanding what goes on here every day operationally. I feel like our senior administration, it's been shown

on our employee satisfaction surveys, they even know it, but they are perceived to be very distant. (Beta, Director of Hospitality)

The existence and failure to enact Rounds seems to produce a negative effect. Staff often cited this as an example of why they felt like senior leadership did not care about them. Failure to enact this routine seemed to produce an effect similar to disenchantment or what Cha and Edmondson (2006) refer to as leader hypocrisy at Beta. Failure to enact these leadership routines also seemed to prevent senior executives from engaging in the subprocesses of compassion towards employees on a regular basis. A greater percentage of Beta participants than Alpha participants described how infrequently these routines were enacted. There is little evidence in the Alpha transcripts to suggest participant perceptions of high or low frequency of the routine's enactment. See Figure 7 for a summary comparison of these routines at Alpha and Beta.

[Insert Figure 7 Here]

Hiring Routines

Alpha and Beta also differed in the nature of the hiring routine template that managers used to assess applicants. Beta was much more explicit in assessing the likelihood that new hires would show compassion. This routine was also enacted more extensively in the organization for a variety of positions for which they were hiring—frontline caregivers as well as support staff. At Alpha, a compassion hiring routine was primarily used when hiring nursing staff and guest services employees, and less so for other positions in the organization. Similarly, Alpha was less explicit in asking questions related to empathy and compassion. Instead, more of the questions related to patient-centeredness—showing respect and dignity to patients, family members and co-workers, information sharing and family and patient involvement and collaboration in care

(Institute for Patient and Family Centered Care 2011). See Figure 8 for a summary chart comparing hiring routines at Alpha and Beta.

[Insert Figure 8 Here]

Socialization

Just as Beta emphasized compassion more in their hiring routines, they also did so in their socialization routines. Beta, more so than Alpha, promoted compassion during job training. Participants from Alpha would often say “we don’t use the word compassion,” but instead focus on more “patient-centered” care (PCC) training programs. Although, this paper does not explicitly examine patient-centered care routines, there is some overlap between patient-centered care and compassion in that champions of patient centered medical homes advocate for compassionate care as part of the partnership between caregiver and patient (American College of Physicians 2007). Nevertheless, they are distinct constructs in the literature such that patient centeredness is primarily structured around the following four principles—respect and dignity, information sharing, participation, and collaboration (Institute for Patient and Family Centered Care 2011; Institute for Healthcare Improvement 2011). Compassion is noticeably absent from this list. Healthcare workers who are expected to engage in patient centered care receive training in those four PCC principles rather than in empathy, compassion, or mercy, explicitly. This difference in training was evident between Alpha, which espoused PCC rather than compassion, and at Beta, which espoused compassion and mercy rather than PCC. Each organization’s training routines incorporated the hospital’s espoused values.

Both engaged in a perspective-taking routine. Beta enacted the perspective taking routine on a more informal basis across the hospital, and transcripts suggest the routine

was encouraged to foster empathy of patient/family suffering. At Alpha, the routine was more formal in nature and somewhat in a more infancy stage. Their patient-family advising program was recently introduced and they were beginning to roll out training across the organization. Participants understood the routine to be associated with fostering a PCC environment rather than empathy with the patient/family.

Alpha and Beta also differed with respect to the mission monitoring routine as well. As part of Alpha's care transformation effort, the hospital placed increasing emphasis on monitoring the extent to which initiatives were aligned with the organization's goals and PCC mission. At Beta though, multiple leaders mentioned a decline in mission monitoring when meetings were internal Beta meetings. However, blessings were still regularly incorporated into meetings with the (Catholic) parent health system. This change in routine was often cited as an example of how many participants describe the "Compassion/Mercy culture" as "slipping." This perception of slipping was discussed by nearly half of the Beta participants. See Figure 9 for a summary chart comparing these routines at Alpha and Beta.

[Insert Figure 9 Here]

Rewards

Alpha and Beta had somewhat similar rewards routines but significantly differed in the extent to which these routines were used throughout the organization and the consistency in the media utilized to record or recognize acts. At Beta, compassion rewards were regularly employed throughout the hospital, utilizing several consistent formats that were either formal or informal (e.g. Angel Cards, monthly Sister O'Hara award, monthly management-level award, annual physician award etc). Nearly every

single participant discussed the Angel Cards, Beta's recognition card routine. Transcripts reveal that they were perceived as both popular and a frequently utilized tool for recording and recognizing acts of compassion.

At Alpha, transcripts suggest this kind of routine was limited to nursing and hospitality staff. Few managers were aware of a recognition card routine. Those who did know about it were often unsure if it was still in use. There were a limited number of ways in which members were recognized formally at Alpha, but an incredibly eclectic and unpredictable number of ways in which units and staff were recognized. In fact, the COO of Beta reveals a high degree of variety in recognition acts, but little evidence of an established pattern of actions that exist to suggest a widely recognized routine to recognize compassion.

Pizza parties, cupcakes delivery around the clock delivered by me and two or three other people. A lot of food, food, photographs, recognition boards, calling people out in front of meetings, the little deal with recognition in the newsletter. Well, you sort of have to sort of put out there why you are there delivering the pizza or the cupcakes. So the message in the association of the trip, the gift, meal, the behavior has to be , so, it may mean, it may be in the form of reading the letter, it may be in the form of a 5 minute speech... but rewards and recognitions we have been told through employee survey is the #1 area we need to do better on. And every time we think we're doing better, being more visible, and then we resurvey, it doesn't move. We've asked staff what would a recognition program look like to you? How do you want to be recognized? You do something great, you do something well and your supervisor wants to recognize you? (Alpha, Chief Operating Officer)

This quote reveals an inconsistent and somewhat chaotic way of recognizing valued behaviors and even less clarity on what those valued behaviors are. By soliciting feedback and asking employees to help them craft a routine, Alpha's COO suggests they are attempting to create a routine that is understood and utilized in a standard manner by

multiple leaders throughout the organization to recognize valued behaviors at work. See Figure 10 for a summary chart comparing rewards routines at Alpha and Beta.

[Insert Figure 10 Here]

Communication

Transcripts from participants at Alpha and Beta reveal that despite the existence of communication routines, these routines were discussed in interviews in a very limited way, and often forgotten or ignored. Both organizations did not appear to differ significantly in how members understood these routines.

I just don't pay attention to print media. It just piles up. (Beta, Ethics Director)

We have an electronic newsletter that I am not sure everybody looks at every month. (Alpha, COO)

In fact, when participants were directly asked what about the environment reminds them to be compassionate, many stated that the imagery of the sick patient itself,—whether it be a print image or an actual patient in a hospital bed, a wheelchair, or walking with an IV pole, served as the reminder.

When you see people walking around with IV poles and breathing equipment, you very quickly realize that your life and others is very fragile, and that you just have to slow down. And it's hard because you get here and it's like I have to get this done and I have to get that done, but when you go out on the floors, you very quickly realize that it could be you. (Alpha, Director of Guest Services)

The use of communication media such as email or newsletters tended to not to be viewed as a distinct routine in itself, but rather aspects of how the other compassion routines are enacted. For example, employees are recognized for showing compassion at work through the Sister O'Hara award. The news of the recipient is then included as part of the hospital's newsletter which describes the member's compassion story. Participants

described the newsletter when they described the rewards routine. See Figure 11 for a comparison between Alpha and Beta.

[Insert Figure 11 Here]

Other Routines: Spiritual

Finally, it was not surprising that spiritual compassion routines were discussed by multiple Beta participants in a way that suggested they were regularly enacted at Beta, a Catholic facility. This is consistent with research which shows that structures do tend to align with an organization's espoused values (Bartunek 1984; Ranson, Hinings, and Greenwood 1980). As a Catholic hospital, I would expect more routines that related to spirituality in both caregiving and in the workplace. The data from Beta support this prediction. See Figure 12 for a comparison of Alpha and Beta

[Insert Figure 12 Here]

3.3.5 Field Research Conclusion

This field study takes an in-depth look at organizational means for fostering compassion and, specifically, how routines may support the expression of compassion in the workplace. The qualitative data reveal a more nuanced nature of how organizations foster compassion through employee support, socialization, leadership, hiring, rewards, communication, and spiritual routines in a hospital setting. Through this research, I am able to show how a variety of these patterns of action support the expression of compassion and thus potentially mitigate workplace suffering. Data reveal that organizations can and do structure to the support the expression of compassion at work. These data also help scholars better understand regular ways in which organizations can

and do structure to attempt to address suffering at its root by cultivating compassion. This research also provides greater insight into ways in which scholars can begin to develop measures to assess the nature and extent to which these compassion routines are utilized in healthcare organizations.

A second finding from the field study relates to the differences in routines and enactments between Alpha and Beta. The data show that a greater variety of compassion routines were used at Beta, that participants were more familiar and knowledgeable of these routines, and told stories that reflected greater usage of these routines. These findings support the theoretical assumption that espoused compassion, at the level of the institution, tends to relate to or align with the structures that were used in the hospital to manage suffering and how people think and act in the workplace (Bartunek 1984; Ranson, Hinings, and Greenwood 1980).

Some of the routines presented in this paper appear to be rather specific to the healthcare industry. However, even specialized routine enactments such as *Sitting with the Dying*, inform our understanding of how organizations more broadly cope with suffering related to sudden loss, decline, or failure. Although employees in non-healthcare fields do not normally experience human death on a daily basis, many do experience other metaphorical forms of death or loss at work (Hazen 2008; Harris and Sutton 1986; Zell 2003). Layoffs, downsizing, the sudden closing of an office, product line, division, or even significant change initiatives, are all workplace events that research has shown can be experienced as a traumatic loss (Hazen 2008). In fact, such losses often trigger stages of grief in employees (Zaslow 2002; Center to Advance Palliative Care 2010; Hui et al. 2010; Anderson and Mangino 2006) similar to Kubler-Ross's framework

on stages of dying (Mahon 2010; Hazen 2008). Therefore, experiencing loss at work, regardless of the industry context, often affects how well people perform. Thus, one can imagine how variations of routines such as “*Sitting with the Dying*” or the “*Grief Ritual*” could prove useful in many settings beyond the healthcare arena⁴ because these are routine ways in which the organization attempts to acknowledge and provide support to employees coping with loss. In so doing, organizations structure to lessen the negative consequences associated with workplace grief (Zaslow 2002).

3.4 Phase 2: Compassion Routines Instrument and Validation Study

In this second phase, I describe how the compassion routines survey instrument was developed in order to measure routine ways that hospital organizations support the expression of compassion in the workplace. This instrument development and validation study is grounded in the findings from the qualitative study. I then validate the compassion routines instrument using a convenience sample of seasoned nurses (RNs). I use seasoned RNs because they are well-positioned in the organization to have a sense for the underlying structures that are in use in their hospital organizations. Additional validation and reliability checks are performed using a second separate sample of hospital executives.

3.4.1 Review of Compassion Routines and Types

This second phase focuses on developing and validating measures of regularized ways of providing employee support, hiring employees, socializing them, rewarding them, communicating with, and leading them. In light of the qualitative findings, I also

⁴ Thank you to Dr. Cristina Gibson for this suggestion.

look at patient care routines as well. Specifically, I focus on how these common routines can become vehicles for the expression of compassion and, in turn, how survey items can attempt to capture ostensive aspects of these routines. At least three items were developed and evaluated for each of the routine types briefly described below.

- a. *Employee Support*: These routines are repeated patterns of action that attempt to provide support to employees experiencing suffering related to personal issues and/or workplace problems. These routines attempt to provide at least one of two forms of support—(1) employee emotional support and (2) tangible hardship assistance.
- b. *Leadership*: These routines either facilitate leaders noticing the suffering of employees, or they create opportunities for empathetic concern for employees—examples of such routines found in healthcare settings include shadowing and feedback.
- c. *Hiring*: These routines relate to the hiring process, and are ways that hospitals screen applicants for fit. Specifically, hospitals use these routines to assess the likelihood that applicants will show compassion at work. Examples include the use of behavioral interviewing to assess compassion and empathy tendencies.
- d. *Socialization*: Regular ways to encourage and remind both new and existing members of the organization to engage in compassion behaviors at work. Examples of this type of routine include the regular practice of perspective taking and mission/values monitoring.
- e. *Rewards*: Regular patterns of actions that recognize or reward the expression of compassion at work using organizational artifacts (e.g. recognition cards and formal awards).
- f. *Communication*: Repeated use of hospital communication media to promote, encourage, or celebrate compassion. In hospitals, this routine is performed using newsletters, email, signage etc.

- g. *Patient Care Routines*: Repeated ways in which the hospital fosters compassion subprocesses towards patients and their families. One routine is similar to employee support routines which provide hardship assistance. However the recipient is a patient or family member rather than an employee. Items were also generated that related to bedside shift reporting and palliative care although the panel of experts agreed with the qualitative study's pilot findings that these items may indeed tap into other constructs. These items were included in the pilot stage but dropped in subsequent survey administration.

3.4.2 Instrument Development and Validation Methods

3.4.2.1 Scale Development Processes and Procedures

In order to develop and examine the psychometric properties of the compassion routines instrument, three samples were used across the scale development and validation stages in order to empirically test the scales. Samples 1 and 2 were used during scale development as pre-testing and pilot testing of the instrument and Sample 3 was used during scale evaluation as part of a large scale test of the instrument. They are described below.

Sample 1

This sample consisted of 25 nursing faculty and graduate students from *Southeastern University's School of Nursing*. Respondents had to have worked in an acute care hospital in the past five years. I asked participants to complete the compassion routines survey instrument developed as a part of this study, as well as provide open-ended qualitative feedback on all items and overall remarks regarding the nature, content, design, and flow of the survey. Respondents were asked to report on their knowledge of

these hospital routines where they previously or currently worked (some graduate students were currently employed).

Sample 2

This sample consisted of seasoned registered nurses (RNs) who have worked as an RN for at least five years. They are considered experienced rather than novice nurses. They served as a proxy for healthcare executive key informants as they are centrally positioned and engage with both clinical and non-clinical staff. They also frequently enact or witness the hospital routines under study. The entire population of seasoned nursing alumni from *Southeastern University's School of Nursing* received the survey request. The survey request was sent as a single email request to a list of just over 1,000 seasoned nurses. Participants were asked to complete the survey only if they were currently employed by a hospital. There were no data metrics available to assess how many of the potential participants who received the email fit the survey inclusion criteria. Although this is a study limitation, the author received multiple emails from participants who contacted the researchers in order to inform the researcher they did not fit the survey screening criteria. This suggests that the inclusion criteria were clearly articulated in the survey's instructions. As such, no follow-up requests to take the survey were performed because non-response may have also been due to respondents not fitting the screening criteria (i.e. not currently employed by a hospital).

194 usable surveys were retained out of a total of 249 of surveys that were initiated. Fifty-five were dropped for one of several reasons—less than half of the survey was completed, comments in the survey revealed the participant did not fit the survey criteria, or the participant's remarks suggested the participant did not understand the

directions in the survey. In order to account for response bias, I ran an ANOVA to check for demographic differences between the retained and dropped sample and no significant difference was found. The demographic role characteristics of the retained sample are as follows. 79.8 percent of the retained sample worked in a general short-term acute care facility. Just over 45 percent of the retained sample included staff RNs, and just over 35 percent of the sample held management positions (i.e. director, Chief Nursing Officer, etc). The descriptive statistics for this group of respondents are found in Figure 13.

[Insert Figure 13 Here]

Sample 3

The compassion routines survey was sent to the Chief Human Resource Officer (CHRO)/ Vice President of Human Resources, Chief Nursing Officer/Director of Nursing (CNO), and the COO/CEO for each general acute care hospital in a random sample of 675 hospitals for a total of 2025 possible respondents. Given their roles, these key informants have sufficient expertise of and familiarity with the ostensive characteristics of these routines as a property of their organizations (Huselid 1995; Guthrie 2001). The 675 hospitals were randomly selected from the population of general short-term non-federal acute care hospitals in the U.S. Contact information for these individuals came from a proprietary mailing list which was cross-referenced with publicly available data, and verified with telephone calls to the hospital when needed. The data from this sample is also part of a separate study examining the relationship between compassion routines and hospital service quality outcomes. The latter is described in the subsequent chapter.

This sample received a paper-based version of this instrument via mail. I used Dillman's tailored design method to increase survey response rates (Dillman 2000). This included four contact attempts to complete the survey as well as additional design

techniques such as regular rather than bulk-rate stamps, university letterhead, and hand-signed letters. Participants were also given the option to complete the survey online or using the paper copy. Only 56 surveys were submitted online, and the remaining surveys were mailed back to the researcher using a postage paid envelope. Four surveys were returned with two pages of missing responses, yielding a sample of 404 responding hospitals to the survey. Of those hospitals surveyed, a total of 585 completed surveys were returned by these executives. Of the completed surveys, 548 had no missing data, and 393 hospitals had no missing data. I performed Little's MCAR test on the data and found that the data was missing completely at random ($\chi^2 = 108$, $p = .668$). As such I performed a listwise deletion and used only survey responses with no missing data. For the purpose of instrument validation, I treated the sample of 548 completed surveys as the responding set in order to treat them similarly to Sample 2 which did not control for place of employment (i.e. multiple respondents were likely to work in the same hospital given the nature of the alumni population's regional employment). Thus the response rate is 27 percent (548 respondents out of 2025). The descriptive statistics for this sample are found in Figure 14.

[Insert Figure 14 Here]

Next I describe, in detail, the process and data used for item generation, scale development and scale evaluation, and the associated analyses.

Item Generation

I followed Hinkin's guidelines (1995) to generate as many relevant items as possible that related to theoretically pre-determined types of routines that support the expression of compassion in the workplace. In accordance with recent research on

routines (Turner and Rindova 2011), these items were then refined using the coding dictionary from the qualitative field study (see Appendix V). A total of 68 items were generated across routine types. One compassion scholar reviewed the list, and it was further refined and some items were re-worded or eliminated.

Because previous scales did not exist for these items, an expert panel of scholars then reviewed the list of items in order to assess content validity. This panel included scholars from the following disciplines and research areas—Organization Theory (2), Organizational Behavior and Compassion (2), Nursing (1), and Marketing (1). This panel examined items to ensure that items were not tapping into multiple constructs and to ensure parsimony of items and appropriate language for the healthcare context. All items were formatted as 1-7 Likert type scales assessing either the extent to which the routines were in use (1=No extent; 7= Great Extent), or the frequency of the routine usage (1=Never; 7=Always). Following a review by the expert panel, and subsequent editing, additions, and deletions, a total of 33 items were approved and utilized in the scale development process. Table 1 contains the definition of each routine type, the number of items generated per type, and a sample of qualitative data that informed the development of routine type items (see Table 1).

[Insert Table 1 Here]

Scale Development

In this next stage, the survey layout was developed following survey layout design guidelines for mail and internet surveys (Dillman 2000). In accordance with Hinkin (1995), the survey containing each of the scales was then administered to a representative sample of the targeted population that would be receiving this survey as part of this larger project. The intended audience for this survey includes hospital

administrators and executives. Since I was interested in ostensive/prescribed aspects of routines, and these prescribed structures of routines are typically set forth by organizational administration, this audience was expected to be the most knowledgeable about the subject of interest in this study. This stage utilized a two stage administration of the scales. First, a pre-test was performed using Sample 1, nursing faculty and graduate students from *Southeastern Medical University* who had worked as an employee in a hospital setting in the previous five years. Qualitative feedback, as well as variance analysis, was used to further refine items as well as the layout and instructions of the survey.

Next, the survey was tested using Sample 2, seasoned nurses who served as a proxy for healthcare executive respondents. 194 usable surveys were returned. The sample size was sufficiently large, and the sample to item ratio was greater than 5:1. Both are appropriate for factor analysis based on recommended guidelines (Floyd and Widaman 1995). Exploratory Factor Analysis (EFA) was then conducted on each of the scales to examine the factor loadings, variance, and reliability of the instrument.

First, all items were examined for psychometric soundness by examining the descriptive statistics for each item using the Sample 2 data from the seasoned nurses. Items with little variance and non-centered means (i.e. average means less than 2 or greater than 6) were further examined and marked for possible deletion from the final survey instrument. The data were subjected to EFA using principal axis factoring in SPSS 17 and an oblique promax rotation as the items were anticipated to correlate with one another. Both a Kaiser-Guttman test (Floyd and Widaman 1995; Gutman 1954; Loehlin 2004) as well as a Cattell-Nelson-Gorsuch scree plot test (Floyd and Widaman 1995;

Gorsuch 1983; Loehlin 2004) were performed in order to examine the factor structure of these items. The Kaiser test produced a five factor solution with eigenvalues greater than one. A Cattell test was also used to examine the scree plot of the factor solution. The scree plot suggested either a four or five factor solution. Previous research recommends using a Cattell test rather than a Kaiser test (Floyd and Widaman 1995; Loehlin 2004) and forcing a factor solution based on the scree plot. As such, both a four and five factor solution were examined; the four factor solution yielded the cleanest solution and was retained. Problematic items previously flagged (i.e. little variance, etc.) were then sequentially dropped and the four factor solution demonstrated even cleaner loadings—no cross loadings and loadings above .32 (Tabachnick and Fidell 2001; Costello and Osborne 2005).

Table 2 contains the items retained in the scales and the four factor solution with loadings and cross loadings. Table 3 shows the loadings and the Cronbach's alpha value demonstrating the reliability of each scale. Table 4 contains the finalized list of items and labels. See Tables 2, 3, and 4.

[Insert Table 2 Here]

[Insert Table 3 Here]

[Insert Table 4 Here]

As seen in the factor loadings table (Table 2), the items did not entirely load according to theoretically predicted routine types. The loadings were then analyzed by the researcher and discussed with both the panel of academic experts as well as with a small panel of nurses in order to make sense of the divergence in findings.

Rewards and Communication Routines

The rewards and communication items collapsed into one factor (shown as Factor 2 in Table 2). The items related to communication primarily focused on the use of communication media to recognize and reward compassion acts. This suggests that communication media were viewed as simply artifacts employed in the performance of rewards routines that recognized compassion. This conclusion is supported by recent routines research on the use of artifacts to execute routines (Turner and Rindova 2011).

Hiring and Socialization Routines

Hiring and socialization routines items also collapsed into a single factor solution. This finding suggests that the way that seasoned nurses experience these routines is perhaps understood as a common routine that promotes and encourages compassion at work. Participants did not view these as distinct routines, but perhaps rather as a common routine executed during different time points in a career (i.e. earliest stage of employment process to ongoing employment processes). This is noted in Table 2 as Factor 1.

Leadership Routines

The leadership items also did not cleanly load on the same factor, but rather split apart across socialization and employee support routine type factors. This suggests that nurses view leadership promotion of compassion as a part of socialization routines. This is similar to how leadership engagement in employee support was also viewed as a part of the employee support routines rather than a distinct leadership routine. This split in leadership items (denoted with 'LDR') is shown in Table 2.

Patient Care Routines

The patient care routines also did not load onto a single factor. This finding suggests that they could also relate to other forms of routines (i.e. socialization and training), or the items are not tapping into a unitary construct. As such, they spread across the factor structure. For example, providing hardship assistance to patients/families loaded with hardship assistance to employees. Although the recipients are distinct, perhaps the similarity in routine performances explains why these items loaded together. This, too, is seen in Table 2. Patient care routines are marked with ‘PC.’

Employee Support Routines

Employee support items split apart on two dimensions that aligned with the nature of the support provided. Items that related to providing emotional or spiritual forms of support loaded on a single factor. This suggests they were viewed as being different from support that was more tangible in nature. Tangible forms included vacation donation programs as well as financial assistance for hardship occurrences. This finding diverges from the qualitative data from healthcare leaders. These executives tended to discuss employee support routines as a collective basket of regular ways that an organization helps employees facing hardship. Whether it is emotional or financial, the field data suggests that leaders tended to view them as a toolkit or basket of possible ways to tailor responses to unique forms of employee pain. This finding may be a result of the mismatch in intended audiences of this survey (healthcare executives, and the proxy sample used in the pilot test, seasoned nurses). This finding suggests that perhaps how these routines are experienced and understood may indeed differ. This finding could

potentially be an artifact of a biased sample of respondents. As such, a second test with Sample 3, the healthcare executives, is used to see if these factor loadings replicate.

Reliability

Finally, Table 3 shows the Cronbach's alpha values associated with each scale. Although some items did not load on the predicted factors, each factor demonstrates reliability. All scales have a value greater than .7, which conforms to generally accepted practices used to demonstrate reliability of a scale (Tabachnick and Fidell 2001; Costello and Osborne 2005). Given the pilot study's factor solution structure, item labels were revised for the retained items. For example, hiring and socialization items loaded on a single factor, suggesting that the items were tapping into a single routine type related to the promotion of compassion. Appendix VII contains the revised labels showing the conversion from the pilot labels to the Sample 3 labels.

Scale Evaluation

The next step in evaluating and verifying the newly constructed scales required additional criterion-related and construct validity testing. Sample 3, which is a sample of healthcare executives, was used to assess validity (Podsakoff, MacKenzie, and Fetter 1993; Skinner, Autry, and Lamb 2009). The survey was sent to healthcare executives from 675 hospitals that were randomly selected from the entire U.S. population of general short-term non-federal acute care hospitals.

I performed factor analysis on these data, and the scree plot test suggested either a three or four factor solution. Both solutions were examined, with the three factor solution yielding the cleanest loadings. This factor solution did differ somewhat from the pilot test. It was analyzed and problematic items were dropped (i.e. no variance, extreme

means). Systematically dropping items yielded a clean three factor solution where Factors 3 (emotional/spiritual support) and 4 (tangible support) collapsed back into one common factor, employee support. This finding supports previous theoretical predictions as well as the qualitative data that show that healthcare executives view support routines as a basket of solutions rather than as two distinct kinds of routines, emotional versus financial/tangible. This factor structure is shown in Table 5.

[Insert Table 5 Here]

Reliability and Validity Testing

Additional validity and reliability checks were performed using the healthcare executives sample data. I assess convergent validity using Cronbach's alpha (CA) (Costello and Osborne 2005; Tabachnick and Fidell 2001), composite reliability (CR), and average variance explained (AVE) values (Chin 1998; Fornell and Larcker 1981; Liang et al. 2007). Some additional items were dropped after examining the AVE values for each scale, and an additional factor analysis was run with a refined list of items. This revised factor structure is located in Table 6. All Cronbach's alpha values exceeded the recommended cut-off value of .70. All CR values exceeded the recommended cut-off value of .70. Finally, the AVE value for each factor was at least .50 (Chin 1998; Liang et al. 2007), with the exception of the Support factor which was .49. However, this is acceptable when viewed in combination with the acceptable values of the other two measures of convergent validity (CA and CR). These results are shown in Table 7.

[Insert Table 6 Here]

[Insert Table 7 Here]

I assess discriminant validity by examining the factor loadings and the square-root of the AVE values for each construct. First, the loadings and cross-loadings show that the items loaded much higher on the assigned construct than on other constructs (See Table 6). The smallest loading for each indicator also exceeds .5. Discriminant validity was satisfactory since the square-root of the AVE values for all constructs were greater than the inter-construct correlations on the factor correlation matrix (Chin 1998). These results are shown in Table 8. The items located in Appendix VIII were retained per factor.

[Insert Table 8 Here]

3.4.3 Phase 2: Discussion and Conclusion

Although the theoretical framework would predict a six factor solution, both the Sample 2 and Sample 3 datasets reveal a more limited factor structure. Routines which were initially theorized as communication and leadership routines collapsed into the following factors—rewards and employee support. One example of this is evident in the way that communication items loaded with the rewards items when they related to the use of communication media to publicize compassion awards winners. This suggests that respondents viewed the repeated use of communication media to recognize compassion acts as a part of the rewards routines. Similarly, leadership involvement in employee support was also viewed as a part of employee support routines rather than as separate routines. Despite leadership items loading onto these factors, they did not load as strongly as other items. After performing validity tests, these items were subsequently dropped. This revision is seen in the final factor structure in Table 6.

Another notable change in the factor structure is how socialization and hiring items collapsed into a single factor. The items which loaded most strongly together all

related to the hiring process. This included items related to on-boarding actions such as orientation. Although orientation is traditionally viewed as a form of socialization, the literature refers to it as a formal tactic which segregates newcomers from other organizational members (Jones 1986; Van Maanen and Schein 1979). It is exclusively performed for newcomers rather than current members of the organization. Because these items related to actions associated with recruiting, assessing, and bringing new employees into the organization, this may explain why these items loaded together into a single factor. The nurses and healthcare executives may not have considered them as distinct routine categories but rather a single one related to hiring. In addition to these items, several socialization items, which also loaded on this same factor, did relate to post-hire patterns of actions. However, these items did not load as strongly. These items were subsequently dropped given validity concerns. Table 6 reflects this revised factor structure.

Study Conclusion

This research reveals three routine types that can become vehicles for the expression of compassion. It is a significant contribution towards understanding compassion structures and, in particular, compassion routines. These initial developments and validation tests are also a first step in validating the compassion routines instrument. The reliability and validity tests reveal that these items are a relatively strong set of compassion routine indicators for three compassion routine types that support the expression of compassion in a hospital setting—hiring, rewards and employee support. Although the factor structure did vary between sample populations, much of the structure is also consistent with the theoretical model. This is a positive step towards the

development of valid and reliable forms of organization-level measures of compassion structures. It is important that future scholarship further validate the instrument as well as empirically test the consequences of compassion routines. Finally, this study also has practical implications. It informs healthcare organizations, and more broadly, service organizations, how to structure to manage workplace suffering and support the expression of compassion.

3.5 Chapter Discussion and Hypotheses for Future Testing

This chapter contributes to a growing literature on organizational compassion by taking a more macro look at compassion in organizations as it is instantiated through an organization's routines. This study moves beyond single organization studies of compassion (Lilius, Kanov, et al. 2011; Dutton et al. 2006) by performing a multi-organization field study, and lays the foundation for developing an instrument to empirically measure compassion routines.

In order for scholars to better understand what effects, if any, compassion has on outcomes that matter to organizations, it is of critical importance to explore how compassion is fostered in organizational life. In so doing, this field study attempted to unpack ways that organizations can and do structure to support the expression of compassion as a means for managing suffering and improving patient quality of care. By taking an in-depth look, we begin to understand not only the nature of these routines, but also how best to structure everyday ways of organizing in contexts such as healthcare where management of suffering is of critical importance to providing high quality care or service (Buller and Buller 1987; Wenrich and Curtis 2003).

This research also informs our understanding of what are some of the different types of routines that support the expression of compassion. These initial tests are also a first step in validating the compassion routines instrument. The reliability and validity tests reveal that these items are a relatively strong set of compassion routine indicators for three compassion routine types that support the expression of compassion in a hospital setting—hiring, rewards, and employee support. Although the factor structure did vary between sample populations, much of the structure is also consistent with theoretical predictions. This is a positive step towards the development of valid and reliable forms of organization-level measures of compassion structures.

For the purpose of this research, I return to the propositions in Chapter 2 in conjunction with this chapter's findings in order to develop testable hypotheses using the compassion routines instrument. In light of the three, rather than six, factor (routine type) structure of the compassion routines instrument, I develop testable hypotheses to examine the relationship between espoused compassion, service quality, and the three routine types. These hypotheses are based on the propositions from Chapter 2. I propose to test the following relationships in the healthcare setting using the data from the random sample of hospitals described earlier in this chapter. As such, I focus on one service quality variable that is relevant in a hospital setting—patient satisfaction. As described in greater detail in Chapter 2, previous research has linked the expression of compassion to patient satisfaction. Expression of compassion in the workplace may also be a means to alleviate suffering. In so doing, employees are better able to do good work. This, in turn, should positively relate to the overall care experience and be reflected in satisfaction ratings of the patient. As such, I hypothesize the following:

H1: The greater the espoused compassion, the higher the patient satisfaction.

H2: The greater use of routines that discuss noticing, feeling, and responding to the suffering of others during the hiring process, the higher the hospital's patient satisfaction.

H3: The greater the use of routines that discuss noticing, feeling, and responding to the suffering of others during the hiring process, the stronger the positive relationship between espoused compassion and the hospital's patient satisfaction.

H4: The greater the use of rewards systems that reinforce noticing, feeling, and responding to the suffering of others, the higher the hospital's patient satisfaction.

H5: The greater the use of rewards systems that reinforce noticing, feeling, and responding to the suffering of others, the stronger the positive relationship between espoused compassion and the hospital's patient satisfaction.

H6: The greater the use of employee support routines to manage organizational suffering, the higher the hospital's patient satisfaction.

H7: The greater the use of employee support routines to manage organizational suffering, the stronger the positive relationship between espoused compassion and the hospital's patient satisfaction.

In the following chapter, I describe an empirical test of these hypotheses using the compassion routines instrument and existing archival data.

4 EMPIRICAL TEST: UNDERSTANDING THE ORGANIZATIONAL EFFECTS OF ESPOUSED COMPASSION AND COMPASSION ROUTINES

4.1 Introduction

In order to better understand what effects, if any, espoused compassion and compassion routines have on important organizational outcomes such as service quality, this chapter provides an empirical test of the hypotheses proposed in Chapter 3. This chapter is organized into four parts: (1) a detailed description of the methods used in this empirical study, (2) a description of the analyses of the data, (3) a description of findings, and (4) a discussion of study findings, limitations, and conclusion.

4.2 Methods

Sample and Procedures

Units of observation for this study were short-term general (non-federal) acute care hospitals in the United States that had at least 26 beds. I restricted the hospital size because having less than 26 beds is part of the criteria to qualify as a Critical Access Hospital, a distinct organizational form (American Hospital Association 2011). In order to determine a minimum sample size for this survey, I performed a Cohen power calculation (Cohen 1988)(Cohen, 1988) using the G*Power program (Faul et al. 2007). I specified an appropriate power level and alpha coefficient in G*Power, given the number of measures as well as anticipated survey response rate to determine an estimation of the required sample size. Given that mail surveys can have low response rates for organizational key respondent surveys including surveys directed towards healthcare executives (Tomaskovic-Devey, Leiter, and Thompson 1994; Baruch and Holtom 2008; Asch, Jedrzejewski, and Christakis 1997; Khaliq, Thompson, and Walston 2006), a

conservatively small response rate was used in order to ensure adequate sample size and power.

Sample Description

A random sample of 675 hospitals was chosen from the population of hospitals in the United States. This is roughly 20 percent of the entire population of these hospitals (American Hospital Association 2010). This sample is the same sample of hospitals used to validate the compassion routines survey instrument described in the previous chapter. All hospitals included in the sample were verified to ensure completeness of archival data required for the hypotheses tested in this study. As described in detail in the measures section of this chapter, the espoused compassion measure, measures of patient satisfaction, and the control variables relied on multiple distinct archival datasets. Any selected hospitals with missing data from these measures were dropped from the sample, and random replacement draws were used from the same population and then verified for data completeness. Less than two percent of the hospitals originally selected had missing data. The remaining measures were collected using survey data.

I designed a multiple respondent design in order to maximize the response rate of hospitals participating in the study. Three executive key respondents from each of the 675 hospitals were selected to receive the surveys. These respondents held one the following three positions—Chief Nursing Officer/Director of Nursing (CNO), Chief Human Resource Officer/ VP Human Resources (CHRO), or Chief Operating Officer/Administrator (COO). Each position has sufficient expertise and familiarity of their hospital organization's structures, making them appropriate key respondents to collect survey data about the nature of the hospital organization (Guthrie 2001; Huselid 1995).

548 surveys were returned with no missing data, yielding a final sample of 393 responding hospitals. This represents a 58 percent organizational response rate which is similar to other health services research surveys (Asch, Jedrzewski, and Christakis 1997). A detailed description of the survey administration process is discussed in the previous chapter. A copy of the survey is located in Appendix IX.

The responding hospital sample resembled the original random draw for most organizational characteristics including size of hospital, Magnet status, Rural/Urban indicator, and teaching status. Responding hospitals had an average of 235.6 beds, a RUCA score of 2.64 indicating an urban facility, just over 8 percent were Magnet certified facilities, and 81 percent were teaching hospitals. These organizational characteristics are all control variables in the model. Previous research has either shown or suggested these hospital characteristics may influence patient satisfaction ratings (Young, Meterko, and Desai 2000). The operationalization of each variable is described in greater detail in the control variable section of this study. The one variable, in which the responding sample did not resemble the population or the initial random draw, related to organizational type. For-profit hospitals were underrepresented in the final sample. 34 percent of the hospitals in the original random draw were for-profit facilities, but only 14 percent responded to the survey. I address the underrepresentation of for-profit facilities in greater detail in the control variables section.

While the unit of analysis is the hospital, limited demographic data was also collected from the executive respondents as well. Nearly 64 percent of the respondents were women, and 35 percent were men. According to a recent survey, 59.8 percent of healthcare executives are female (Friedman and Frogner 2010). Given that the nursing

profession is predominantly female, it is of little surprise that 197 out of 214 responding CNOs were female. Similarly, according to ASHHRA, the professional association for human resource professionals in healthcare, women outnumber men 2 to 1, and the average member of ASHHRA holds an executive or director level position (American Society for Healthcare Human Resources Administration 2009). As such, I expected women to comprise the majority of respondents given the percentage of women in healthcare executive positions, particularly in CNO and CHRO positions. Finally, respondent hospital tenure averaged approximately 13 years.

Response Bias

In order to test for response bias, I performed several tests. First, I performed a wave analysis to evaluate nonresponse bias by comparing early versus late responders (Rogelberg and Stanton 2007). I ran an ANOVA to compare early versus late responders' responses to the survey items. No significant difference was found between the two groups in how they answered the survey questions. Second, I examined nonresponse bias as a function of the dependent variable of interest—patient satisfaction. Given the study's interest in understanding the effects of compassion routines on patient satisfaction, I wanted to determine whether a significant difference in patient satisfaction ratings existed between responding and non-responding hospitals. Two separate ANOVAs were run with survey response (“yes/no”) as the independent variable and patient satisfaction as the dependent variable using each of the two patient satisfaction measures (“RATING” and “RECOMMEND”). A significant difference was found for one of the two patient satisfaction measures—“RATING.” In order to control for the bias in response rates, I create a weighted measure, “RATING_WT,” that was used in the subsequent regression

analyses. The measure “RATING_WT” is the inverse of RATING ($1/\text{RATING}$). I use RATING_WT to assign weights to each responding case in order to more heavily weight hospitals with lower RATING scores, as they are underrepresented in the final sample. The patient satisfaction measures “RATING” and “RECOMMEND” that are briefly mentioned above are described in detail below.

Dependent Variable

Patient Satisfaction: I measure patient satisfaction using available archival data from the Hospital Compare Medicare website containing patient satisfaction scores. Patient satisfaction data was collected by a national survey, HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), and is a standardized survey of hospital patients and reported patient satisfaction. HCAHPS was created to publicly report the patient’s perspective of hospital care. The survey asks a random sample of recently discharged patients about aspects of their hospital experience. HCAHPS was developed by a partnership of public and private organizations including the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) (HCAHPS Hospital Care Quality Information for the Consumer Perspective 2009). The HCAHPS results posted on the Medicare website report on ten summary measures of patients' perspectives of care including measures related to nursing, communication, management of pain, responsiveness, and the discharge process. In addition, HCAHPS contains two global measures of patient satisfaction with the hospital experience—overall rating of the hospital (RATING) and the likelihood of recommending the hospital to a friend or family member (RECOMMEND). For the purpose of this study I use the latter two measures— RATING and RECOMMEND as

they are global summary measures of the hospital rather than measures that are specific to certain job functions (i.e. nursing measures). HCAHPS data are based on four quarters worth of rolling data, and I use the data released in December of 2010 which is two months prior to the survey's administration. The RATING measure is an interval measure (a scale of 1-10), and RECOMMEND is categorical, however the data is released as proportional data giving the percentage of patients reporting "top-box, middle-box, and lowest box scores (HCAHPS Hospital Care Quality Information for the Consumer Perspective 2009)." The RATING data consists of the proportions of ratings in the highest rating (9-10), a high rating (7-8) or a low rating (1-6) for each hospital for each item. RECOMMEND is released as the proportion of respondents giving the highest score of "Definitely Recommend," then "Probably Recommend," and then the lowest, "Definitely Not Recommend." The wording for each item is located in Appendix X. I use the proportional data for the highest "top-box" score for each measure, ratings of 9 or 10 for RATING, and those who would definitely recommend a hospital for the RECOMMEND measure. Given that these data are released as percentages or proportions, both measures are then transformed using an arcsine-root transformation. This is a variance-stabilizing transformation commonly used to transform proportions in order to normalize the data (Osborne 2002).

Independent Variables

Espoused Compassion: I measure espoused compassion by examining hospital websites which contain the organization's mission and values statements. I collected data in the fall of 2010 regarding espoused compassion through a systematic search of all respondent hospital websites in order to measure the extent to which these organizations publicly

espouse compassion as a core value or a way of working in their mission and values statements. I do so by taking counts of the use of the word ‘compassion,’ and compassion stem words (e.g. compassionate) on the hospital website. Prior to drawing the random sample of hospitals, a preliminary study searching hospital URLs for the terms compassion and mission suggested these data were widely available. I also recorded the total number of words listed in the online mission and values statements and created a variable that divides the number of references to compassion by the total number of words in the online statement. This calculation reflects the prominence of compassion in the online statement. This variable is listed as “COMP_RATIO” and is a continuous measure. This measure is modeled after online marketing and in particular search engine optimization strategies using keyword density. Keyword density is an indicator of prominence of a topic based on the number of times it is mentioned proportional to the content on the webpage (Bradley 2002). I also created a separate dichotomous variable to capture whether or not a hospital espoused compassion and used effect coding to assign values (Aiken 1991). Espoused compassion is equal to 1, and no espoused compassion is recorded as -1. This variable is listed as “COMP_d.” I ran all regression models for each of these two measures of espoused compassion in order to better understand if there were differential effects between the prominence and extent of the espoused compassion or simply espousing compassion.

Hiring Routines: I use the compassion hiring routines scale developed from the compassion routines instrument described in the previous chapter. I use this scale in order to create an index measure of the extent of use of compassion hiring routines in each hospital. These items relate to repeated hiring actions including recruitment,

interviewing, and on-boarding that support the expression of compassion subprocesses. This scale consists of four Likert scale items, with each question scaled from 1-7. It is a reflective measure, and has a Cronbach's alpha of .81. I sum the four items and calculate the z-score of the index value to create a standardized measure. An example of an item from this scale is "To what extent does new hire orientation training emphasize the importance of compassion amongst all staff in the hospital?" A complete list of these items is found in Appendix VIII. This measure is represented in the analysis tables as "HIRE."

Rewards Routines: I use the rewards scale from the compassion routines instrument. It consists of three items that assess the extent and frequency that a hospital reinforces noticing, feeling, or responding to the suffering of others through recognition acts. This scale consists of three Likert scale items, with each question scaled from 1-7. It is a reflective measure, and has a Cronbach's alpha of .82. I sum the three items and calculate the z-score of the sum to create an index measure. An example of an item from this scale is "To what extent does the hospital have compassionate caregiver/employee award programs (e.g. DAISY Award, awards for Clinical Staff, awards for Support Staff)?" A complete list of the scale's items is located in Appendix VIII. This measure is represented in the analysis tables as "REWARD."

Support Routines: I use the employee support scale from the compassion routines instrument. It consists of three items that assess the extent and frequency that the hospital facilitates or provides support for hospital members facing hardship or suffering. This scale consists of three Likert scale items, with each question scaled from 1-7. It is a reflective measure, and has a satisfactory Cronbach's alpha of .74. I sum the three items

and calculate the z-score of the sum to create an index measure. An example of an item from this scale is “How often does your hospital facilitate support sessions for departments/units dealing with things like crisis events, conflict, trauma, or workplace stress?” A complete list of these items is located in Appendix VIII. This measure is represented in the analysis tables as “SUPPORT.”

Control Variables

Multiple archival sources are used as a source for theoretically relevant control variables pertaining to hospital characteristics. These sources contain data for over 6,000 U.S. hospitals, including over 4,000 community hospitals. Data fields in these archival sources include key control variables—organizational size, teaching status, Magnet designation, organizational type, and geographic location. The data sources include but are not limited to the American Hospital Association's annual survey, the American Hospital Directory (American Hospital Association 2009; American Hospital Directory 2009), and a proprietary database. Specific data sources are described in detail for each control variable.

Organizational size: This variable is a continuous variable calculated using the total number of patient beds in a given hospital. Size is an important control variable because previous research has shown that organizational size significantly and negatively relates to patient satisfaction ratings in hospitals (Young, Meterko, and Desai 2000; Fleming 1981; Jha et al. 2008). I use a proprietary database containing the number of beds for each hospital to create this measure. This variable is represented in the analysis tables as “SIZE.”

Rural/Urban: Some research on patient satisfaction has shown that rural patients tend to report higher patient satisfaction than urban patients (Young, Meterko, and Desai 2000; Fleming 1981). As such, I include this as a control variable to control for its effects. I use the rural urban commuting code (RUCA) used in health services research. Values range from 1-10, and the higher the score the more rural the hospital. RUCA scores were calculated according to 2000 census tract characteristics and 2006 zip codes such as population density, urbanization, and daily commuting patterns within a given zip code (United States Department of Agriculture 2000). RUCA scores are maintained for all zip codes in the United States and each RUCA score was retrieved from the publicly available RUCA Rural Research Center database based on each hospital's zip code (Rural Health Research Center 2004). Hospital zip codes were retrieved from the proprietary database. RUCA scores are used in other health services research where rural or urban health are characteristics of interest for the research study (see for example, Ross et al. 2008; Doty et al. 2008; Dimick and Finlayson 2006). This variable is represented in the table as "RUCA."

Teaching status: Multiple studies have proposed that teaching status, measured dichotomously as belonging to the Council of Teaching Hospitals (COTH) (Fleming 1981; Jha et al. 2008), may also impact patient satisfaction scores. Scholars have theorized that teaching hospitals have a larger variety of goals (Fleming 1981), and may focus on more technical aspects of care rather than patient experience (Jha et al. 2008). It is interesting to note that recent research does not find a significant difference in patient satisfaction scores using the HCAHPS data (Jha et al. 2008). According to COTH, 400 hospitals are considered teaching hospitals, and approximately three-quarters of those

members are general acute care hospitals. The remaining one quarter consists of federal facilities such as Veteran Medical centers, mental health hospitals, and rehabilitation hospitals (Association of American Medical Colleges 2009). Teaching status is represented in the analysis table as variable “TEACH” where 1= teaching hospital and 0=non-teaching facility. I use the AHA guide, the AHD directory, and the proprietary database to determine teaching status and include it as a potential explanatory variable in order to control for its effects.

Magnet Status: I include Magnet status as a control variable in this model. Magnet is a nursing credential program that recognizes excellence in nursing care within a hospital based on criteria set forth by the American Nurses Credentialing Center (ANCC) (American Nurses Credentialing Center 2011). Previous research by Aiken and colleagues has shown that hospitals that are Magnet certified have higher patient satisfaction ratings (Aiken, Havens, and Sloane 2000; Havens and Aiken 1999). A current directory of Magnet designated hospitals is maintained online at the ANCC website (American Nurses Credentialing Center 2011). All hospitals were coded for magnet status using this directory. Magnet hospitals are coded as “1” and non-Magnet hospitals are coded as “0.” Magnet status is represented in the analysis section as variable “MAGNET.”

Profit Status/Ownership: Previous research using HCAHPS data has shown that for-profit status is negatively associated with patient satisfaction (Jha et al. 2008; Lehrman et al. 2010). For-profit status is coded as a dichotomous variable, “PROFIT” where 1=for-profit and 0= not-for-profit. According to this research, non-profit status hospitals outperform for-profit facilities on HCAHPS ratings. As noted previously, higher

HCAHPS performing hospitals disproportionately responded to the survey. In order to correct for this non-response bias, a case weight was created that is the inverse of the global “RATING” measure of patient satisfaction and is used for regression purposes to more heavily weight lower rated hospitals. Since for-profit status hospitals are also underrepresented in the respondent sample, and for-profit status predicts lower patient satisfaction scores, the case weight will help correct for this underrepresented group of hospitals.

Finally, because this research is focused on understanding the effects of compassion structuring, and compassion is a value which is often associated with religiously affiliated hospitals including Catholic facilities (White and Dandi 2009), I added a second dummy variable for religiously affiliated hospitals. While previous research does not find a significant relationship between religious affiliation and patient satisfaction, the variable was included in order to account and control for any effects associated with being a religious hospital that is distinct from espousing compassion or enacting compassion routines. Hospitals that were religiously affiliated were coded as 1, non-religiously affiliated hospitals were coded as 0. This variable is listed as “RELIGIOUS” in the analyses. I used the proprietary database, the AHA guide, as well as the HCAHPS database which contains organizational type information. Initial classifications were cross-referenced with each source. Where differences existed, they were investigated and the appropriate classification was selected.

Aggregation

To ensure that the compassion routines scales were meaningful at the hospital level, survey questions were designed to ask respondents to report on the extent or

frequency that the hospital enacted or utilized different routine types. Thus, all items focused the respondent on how things were done at their organization rather than on their opinion about these routines in their hospital.

In order to statistically justify aggregation of key respondent data per hospital, several statistical tests were performed as well to demonstrate that (1) there is significant variance between hospitals for each of the survey's routine measures (for hospitals with multiple respondents), and (2) hospitals with multiple respondents reported similar scores on routine measures. Four measures of within-hospital agreement were used to examine the degree of convergence of responses. First, I ran an ANOVA to test for significant differences in routine measures for those hospitals that had multiple respondents based on hospital affiliation. A significant F-statistic ($p < .001$), with hospital affiliation as the independent variable and the three routine indices as the dependent variables, indicated that responses differed between respondents from different hospitals. This is the first step in justifying aggregation of respondents. Using multiple respondents to report on characteristics of the organizations assumes that respondents are interchangeable raters. I wanted to eliminate the possibility that respondents systematically responded differently to the survey based on their role in the organization. As a result, I ran a second ANOVA to test for significant differences in routine measures for these hospitals where role (e.g. CNO, CHRO or COO) was the independent variable and the routine index scores were the dependent variables.

A non-significant F-statistic for both REWARDS and SUPPORT ($p > .05$) reveal that these respondent types did not respond differently based on their organizational role. However, there was a significant F-statistic for the hiring routine measure "HIRE"

($p < .01$). CNOs systematically responded differently than COOs and CHROs for the HIRE scale. However, there was no significant difference in how COOs and CHROs answered the same scale's items ($p > .05$). This difference is potentially due to the fact that the hiring and on-boarding process within nursing may differ systematically for nursing versus non-nursing staff. The use of nursing specific residency programs to recruit novice RNs and provide RN specific on-boarding and orientation typically falls under the purview of nursing administration more so than the Human Resource office (Krugman et al. 2006). So, the process itself may differ enough in how the routines are enacted. Trends in nursing recruitment and on-boarding reveal a growing use of residency programs, preceptors, etc. (Lindsey and Kleiner 2005; Krugman et al. 2006). This, in turn, may explain a systematic difference in how CNOs, who are more focused on nurse hiring, answered the HIRE items than the COO and/or CHRO from the same hospital. The implication of this difference in CNO respondents is addressed in the subsequent paragraph section under the *Justifying Aggregation* header.

Finally, I also examine ICC(1) and ICC(2), intraclass correlation measures, in order to determine whether or not there is agreement between raters for each scale. ICC measures are used to assess the degree of homogeneity of respondents from the same hospital. ICC(1) reflects the total proportion of variance explained by hospital membership (working for the same hospital). ICC(2) provides an overall measure for the reliability of aggregated means. $ICC(1)_{REWARD} = .71$ and is significant ($p < .01$), $ICC(1)_{SUPPORT} = .68$ and is significant ($p < .01$). Given the difference in CNO responses to the HIRE scale, I examine the ICC(1) excluding CNO responses, and $ICC(1)_{HIRE} = .51$ and is significant ($p < .01$). Researchers generally justify aggregation when the ICC(1) F-

statistic is significant (Klein and Kozlowski 2000). ICC(2) measures are as follows: $ICC(2)_{REWARD} = .83$ and $ICC(2)_{SUPPORT} = .81$. I exclude CNO responses and calculate $ICC(2)_{HIRE} = .71$. These values exceed the .70 threshold for aggregation (Klein and Kozlowski 2000) and provide strong support for aggregation. The issues related to CNO responses to the HIRE scale are discussed below. Finally, I do not calculate the rwg index (James, Demaree, and Wolf 1984) to assess agreement as it is not appropriate for small sample sizes. Responding hospitals only had at most two or three raters, which is less than the 10 raters recommended for adequately assessing agreement using rwg (Brown and Hauenstein 2005; James, Demaree, and Wolf 1984; Lindell, Brandt, and Whitney 1999).

Given the support for aggregation, rewards and employee support scales will be aggregated using an unweighted mean (Wagner, Rau, and Lindemann 2010) for each index. Given the significant difference between CNO and non-CNO respondents to the hiring routines scale, I divide the sample into two subsamples in order to run parallel regressions for these subsamples in order to account for this difference. First, I created two separate variables for the hiring routines scale for each hospital. The first, HIRE, is an unweighted mean score that aggregates COO and CHRO responses, excluding CNO responses. Second, I create a nursing only hiring routine variable for the same scale that contains the standardized index score for the responding CNO for each hospital: "HIRE_n". In so doing, I am able to run regression tests in parallel for both subsamples—all responding hospitals where at least a COO or CHRO responded (subsample 1, "SS1"), and a second subsample comprised of only CNO respondents (subsample two, "SS2"). For SS1, the HIRE value is the standardized mean of COO and

CHRO responses, and the SUPPORT and REWARDS values are the standardized means from responding CNO, CHRO, and COOs. For hospitals that had a CNO and either (or both) CHRO and COO respond, CNO responses were included in the REWARDS and SUPPORT measures for the hospital because CNOs did not systematically respond differently than the other executive types for these two other scales. By running tests in parallel, I am able to see if regression results for each subsample follow similar patterns of significance and direction (positive and negative coefficients) and if certain independent variables similarly or differentially predict HCAHPS patient satisfaction.

Based on the aggregation measures, and previous research practice (Yount and Snell 2004; Becker and Huselid 2006), I merge single respondent and multiple respondent hospitals because the aggregation tests show that executives from the same hospital provided similar responses. These tests provide evidence which suggests that whether I had one or several respondents from the same hospital, the responses would be similar. Combining these responding hospitals also maximizes sample sizes in the regression analyses. Nevertheless, because of the divergence in the way respondents responded to the HIRE scale, the sample remains split into two subsamples (SS1 and SS2), and those regressions are run in parallel. This reduces overall sample size used in the regression analyses. The subsample sizes are as follows: $N_{SS1} = 275$ and $N_{SS2} = 214$. Of those 275 in SS1, 97 have multiple respondents including a CNO. Those CNO data points are reflected in the SUPPORT and REWARD average index scores but not the HIRE measure. The subsample size of SS2 is $N_{SS2} = 214$ and only contains CNO respondents. Despite smaller sample sizes, there is still sufficient power for the regression testing.

Data Analyses

By weighting each hospital case by the inverse of its patient satisfaction rating, I chose weighted least-squares (WLS) regression rather than traditional ordinary least squares (OLS) regression to test the hypotheses. The Durbin-Watson statistic for the patient satisfaction measure “RATING” is equal to 1.85, less than the 2.0 threshold for demonstrating no autocorrelation in the data. This makes WLS an appropriate choice given the heteroskedasticity of the dependent variable. I also ran additional tests to determine the appropriateness of WLS. I examined the measures for multicollinearity by examining binary correlations, the Variance Inflation Factor (VIF) values for all variables in my model, and the tolerance levels to detect multicollinearity. Correlations are shown in Table 9 and reveal no particularly high correlations. All VIF values are less than 10 and the average of VIFs for all variables is reasonably close to 1. Tolerance levels for all variables are greater than .10. I also examined plots to examine the linearity between the dependent and independent variables. These plots did not show evidence of non-linear relationships between independent and dependent data.

4.3 Results

Descriptive statistics for the study variables are contained in Table 9 for the entire sample. Table 9 also contains the binary correlations of all study variables. I conducted WLS analyses to test the hypotheses using each subsample—SS1 and SS2 in parallel. Table 10 depicts the results for Model 1 for each subsample which tests the main effects of the independent variables as well as Model 2 which tests for the interaction effects for each subsample. Each regression model was run for both the subsample SS1 and SS2, for each dependent variable—RECOMMEND and RATING. Because espoused compassion

was operationalized using two different measures, one being a measure of prominence of espoused compassion (“Comp_ratio”), and the other being a dichotomous measure of whether or not compassion is espoused (“Comp_d). These models were all run twice, first with the Comp_ratio variable and second with Comp_d variable. Given the number of regression models, I first compared the results across all models for Comp_ratio and Comp_d and see a consistency in findings regardless of which operationalization used. All regression models for both subsamples have larger R^2 values when Comp_d rather than Comp_ratio is used. In the interest of parsimony, the regression results discussed relate to models which used Comp_d as the measure of espoused compassion given its greater explanatory power⁵. Table 10 reports the results of these multivariate tests using the Comp_d measure.

In hypothesis 1, I predicted a relationship between espoused compassion and patient satisfaction. Regression models 1 and 2 show a significant relationship between espoused compassion and both patient satisfaction scores for the aggregate sample SS1, but in the opposite direction. While not a significant result, the nursing subsample also shows a relationship in the opposite direction between the predicted positive relationship between espoused compassion and patient satisfaction. Thus, hypothesis 1 is not supported and this finding is addressed in the discussion section. In support of hypothesis 2, regression models 1 and 2 show a significant positive relationship between hiring routines and patient satisfaction for the RATING dependent variable. The interaction term of espoused compassion and hiring routines has no significant relationship with either patient satisfaction measure. This is shown in Model 2 for each sample, for each

⁵ Table 11 shows regression results for the same multivariate tests using the Comp_ratio measure of espoused compassion.

dependent variable. As a result, I find no support for hypothesis 3. I also find no significant relationship between rewards routines and patient satisfaction variables for either subsample. This is shown in Model 1 for each dependent variable for each subsample, thus hypothesis 4 is not supported. Model 2 for each dependent variable, for each subsample, also shows no significant relationship between the interaction term of rewards routines and espoused compassion and either patient satisfaction measure. As such, hypothesis 5 is not supported. Models 1 and 2 for the nursing subsample show a significant relationship between the support routine for both patient satisfaction dependent variables (hospital rating variable "RATING," and the variable that measures the likelihood of recommending the hospital to friends and family "RECOMMEND"). Models 1 and 2 for the aggregate sample SS1 also show a significant relationship between support routines and the likelihood to recommend patient satisfaction measure "RECOMMEND." Although there is no significant relationship between support routines and the RATING measure for SS1, similar findings across both samples for the RECOMMEND measure of patient satisfaction support hypothesis 6's prediction for at least one form of patient satisfaction. Significant findings for both measures for the nursing subsample SS2 lend additional support to hypothesis 6. None of the models with the interaction term between support and espoused compassion show a significant effect on patient satisfaction. These results show no support for hypothesis 7.

4.4 Discussion and Conclusion

The aggregate sample, SS1, shows a clear relationship between espoused compassion and patient satisfaction (H1), between hiring routines and the overall hospital patient satisfaction global rating "RATING" (H2), and between support routines and the

second global patient satisfaction measure—the likelihood of recommending the hospital to friends and family (H6). However, the results were not identically replicated with the CNO only sample. One option could have been to have eliminated CNO responses from the regression tests because aggregation analysis tests revealed a systematic difference in how CNOs answered the hiring routines question. However this systematic difference in responses brought to the forefront the complexity of assessing routines at the hospital level using key informant data given the nature of how routines are enacted in hospitals. On the one hand, results suggest that routines should be measured at a more micro level—between clinical and non-clinical domains (i.e. nursing and the non-nursing staff). This is in line with some research which shows that nursing care in itself is a significant driver of patient satisfaction scores (Aiken, Havens, and Sloane 2000). This is evident in the significant relationship between the Magnet designation control variable, a measure of nursing excellence, and patient satisfaction. Perhaps how these routines are enacted within the clinical domains and for non-clinical staff differ; they have differential effects on patient satisfaction. In this way, measuring routines at this lower level of analysis suggests a kind of formative or additive measure of hospital routines consisting of these different perspectives. Perhaps failure to fully capture these lower level assessments of these routines leads to an incomplete picture. Further inquiry is needed into understanding routines performed by different professional groups within an organization. Ostensive aspects of routine are tied to the specific performances of these routines, and the doing of the work shapes these stored templates. When different professional groups perform these routines in different ways, this too would be reflected

in how they understand them, or the ostensive aspects of the routines which this research explored.

On the other hand, while CNOs have significant oversight in a hospital, the nature of their work is quite focused on the nursing function. How they report on these routines is most likely geared towards nursing only rather than as an overall picture or assessment of the hospital's patterns of actions. This suggests that a more appropriate sample would consist of HR and operations executives, namely CHROs, COOs, and head administrators who are tasked with managing the entire workforce, regardless of the different role type or employment relationship of individuals who work in the hospital. These are questions that future scholarship should address.

Nevertheless, the findings which show significant relationships between support routines and hiring routines and these global measures of patient satisfaction have potentially significant implications for hospitals and healthcare organizations. It is interesting to note that while hiring routines may affect overall hospital ratings, it appears that the support routines may drive the likelihood that a patient recommends the facility to family members. Both measures have significant organizational implications. With Medicare tying reimbursement to HCAPHS ratings as part of the switch to value based purchasing (VBP) (Centers for Medicare & Medicaid Services 2011), both are important from a fiscal standpoint. However, given the strategic implications of patient word-of-mouth, the support routines themselves may be an important driver of not only the extent to which hospitals maintain but gain market share and competitive advantage (Winston 1988; MacStravic 1995). This is especially important in markets where patients have a choice in care providers.

Another curious finding is that espoused compassion is negatively associated with patient satisfaction scores. This finding is somewhat perplexing and suggests that even when controlling for other explanatory variables, espousing compassion is potentially harmful to hospitals. Perhaps, espousing compassion raises the service expectations that patients and their family members have for the care experience. This in turn makes it more difficult for these hospitals to both meet and exceed expectations. When patients expect a certain degree of compassion, experienced compassion may be perceived as an expected behavior rather than one that exceeds patients' expectations. This could explain this negative effect. By raising service expectations, hospitals may be hurting their own evaluations because the experience does not live up to or meet patients' expectations of a compassionate care experience. Future scholarship should further investigate this finding.

The empirical findings also did not support the prediction of a positive relationship between rewards routines and patient satisfaction. Generally speaking, organization research shows a clear linkage between pay and performance which explains why scholars and practitioners alike argue that rewards should be aligned with valued behaviors and goals (Kerr 1995; Lawler 1971, 1977). My findings show that the relationship was not significant between compassion rewards routines and patient satisfaction. This suggests that managers and executives interested in maintaining and improving patient satisfaction scores and HCAPHS global ratings in particular, would be better served by investing their resources and focusing attention on the hiring and employee support routines. This sample suggests that rewards related to compassion behavior do not impact patient satisfaction and thus are a less appropriate strategy for

administrators to pursue. Nevertheless, this is a question which future scholarship should address.

Limitations

Despite significance in some of the findings of this study, it is important to recognize several limitations of these results as well. First, these data are cross-sectional rather than longitudinal data. Rather than demonstrate causality, these results simply show relationships which future scholarship should test using longitudinal datasets in order to replicate these findings. A second limitation of this study relates to the patient satisfaction measures. HCAHPS patient satisfaction data used in this study consists of four quarters of averaged data rather than a snapshot of patient satisfaction at one point in time. Furthermore, the data used in this study consist of data collected in 2010 and does not include data from the first quarter of 2011. Given that the routines survey was collected between February and April of 2011, the routines data may be stale or inaccurate. It would be appropriate to re-run these regressions when data containing the first quarter of 2011 is released in order to try and replicate these findings.

Another methodological issue of this study is the compassion routines instrument. Despite initial validity and reliability tests of this instrument described in the previous chapter, further tests should be conducted to validate the instrument and the goodness of fit of the factor structure. Another acknowledged limitation of this study pertains to the difference between CNO and non-CNO respondents. This may be due to CNOs being an inappropriate respondent, or it may reflect a level of analysis flaw in the design and administration of the compassion routines instrument. Finally, this research was conducted using short-term general acute care hospitals in the U.S. In so doing, this

potentially limits the generalizability of these findings to acute care hospitals, or perhaps even only to U.S. acute care hospitals. Nevertheless, the nature of the compassion routines instrument was designed for different types of healthcare organizations, with the possibility of modifying certain phrasing and using it for service organizations broadly. One could imagine that words such as “patient” could be replaced with “customer” and the items would still tap into the same construct. For instance, the hiring question about taking the perspective of patients/family members could easily be modified to state “perspective of customers.”

Conclusion

Despite these limitations, the findings of this study are an important first step in building the business case for why compassion matters (Frost 1999), and in particular for healthcare organizations. While traditional research has focused on either nursing care or more coarse measures of organizational characteristics such as teaching or profit status, this study attempts to provide insight into one specific kind of structure that may drive patient satisfaction and why it does. Routines that support the expression of compassion become the means by which hospitals attend to workplace suffering. In so doing, routines that encourage compassion towards patients and family members may directly influence patient perceptions of quality of care. Routines that attend to employee suffering may mitigate the costly effects of suffering on individuals and the organization. In so doing, HCOs indirectly shape the patient experience by enabling employees to be at their best. This research attempts to provide a deeper explanation of how and why specific structural interventions can positively benefit the organization. Although this research is more focused on hospital routines, routines that manage workplace suffering may have

implications that are much farther reaching. This is especially true for service organizations that deal with the general public on a regular basis. Perhaps routines that attend to workplace suffering impact not only perceptions of customer satisfaction, but also other measures of service quality because they institutionalize compassionate responding in order to mitigate the harmful effects of suffering (i.e. distracted or impaired employees).

5 SUMMARY and DISCUSSION

In this chapter I provide a summary of findings from the qualitative field study and instrument development study, as well as the empirical study described in the previous chapter. I also discuss the implications of these studies and in particular their contribution to compassion and routines research. I also discuss the implications for this research for both healthcare and service organizations. Finally, I discuss future opportunities for research that build off this line of inquiry.

Implications for Compassion Research

The qualitative research and instrument development and validation study together show that organizations can and do structure to support the expression of compassion. The routines that were observed in practice, and measured using the compassion routines instrument, did not conform to the initial theoretical predictions. The data show that how organizational scholars classify routines does not perfectly align with how the professionals who enact these routines think about and perform them. However, the findings did confirm what scholars like Dutton and her colleagues have suggested and documented in singular organizational studies (Dutton et al. 2006; O'Donohoe and Turley 2006)—routines can indeed become vehicles for the expression of compassion. These routines can be single or multi-faceted, supporting noticing, empathy, responding, or a combination of these subprocesses. The field data as well empirical data collected from the nearly 400 hospitals included in this study reveal that organizations can and do structure to manage suffering through regular actions that attempt to notice, feel, and respond to the suffering of both patients/family members and employees/members of the

organization. The instrument development and validation study also confirms a subset of the compassion routine types proposed in Chapter 2.

Routines that encourage compassion subprocesses of noticing, perspective taking, and responding throughout the organization are enacted during hiring processes, rewards and recognition programs, and again in the process of providing support to employees facing hardship or suffering. Some routines appear rather similar but are performed for different intended targets (i.e. employees/members of the organization as one audience and patients/family members as a second audience). Examples of such routines include the regular practice of structuring to provide financial assistance to patients and employees. Patients receive assistance in the form of vouchers, discounts, lodging, etc. Employees receive assistance in the form of grants, loans, gift certificates, etc. Hospitals use their pastoral care staff to provide emotional and spiritual support for their patients. In some of these organizations, pastoral care also regularly attends to the spiritual and emotional needs of the staff as well. These hospital routines examples reveal similar patterns of actions that are regularly enacted in order to mitigate suffering not only of those patients cared for in the hospital, but also of those who care for the patients. Through the qualitative field research, I am also able to show a more nuanced look at the nature of these compassion routines which future scholarship should continue to explore.

This qualitative study also informed the development and validation of the compassion routines instrument. The compassion routines survey instrument is the first organization-level measure that, to my knowledge, attempts to measure compassion structures for an organization. This development in itself is a direct attempt to build off of previous compassion scholarship which suggests that organizations can structure to foster

compassion (Dutton et al. 2006), and that organizational compassion benefits the organization (Lilius, Kanov, et al. 2011; Lilius, Worline, et al. 2011). By developing and validating an empirical measure, the compassion routines instrument can be used to examine the implications, at an organizational level, of compassion structures. In so doing, it answers the call for more macro level compassion measures (Lilius, Kanov, et al. 2011).

The empirical test of the relationship between compassion routines and service quality is a significant first step towards understanding how, in the words of Peter Frost, “compassion counts” for organizations (Frost 1999). If compassion can relieve suffering at the individual level, and it can produce positive individual outcomes, it follows that collectively, compassion can attend to workplace suffering. Routines that support the expression of compassion are a means by which organizations can encourage, support, and promote attending to suffering not only of customers but of co-workers as well. These routines embed compassion into an everyday way of working. Previous research has continued to show the costly effects of suffering (AbuAlRub 2004; Pfifferling and Gilley 2000; Maslach and Goldberg 1998; Figley 1995; Mallett et al. 1991; Maslach 1982). Minimizing them, especially in healthcare, is a means to ensure higher quality care experiences for patients and family members. Mitigating suffering means employees are better able to do good work. This directly impacts many aspects of the care experience for the patient. The empirical findings, which will be discussed in greater detail, demonstrate that compassion routines do benefit the organization.

Theoretical Implications of the Empirical Test

Contrary to the predicted relationship, the empirical study finds a negative relationship between espoused compassion and both HCAHPS global measures. These empirical results suggest that it is possible that simply being a values-driven organization increases the likelihood of influencing patients and employees' perceptions and expectations of standards of care, and in this case, how "compassionate" the care experience or workplace *should* be. For patients, espoused compassion may influence service expectations (Oliver 1997; Zeithaml, Berry, and Parasuraman 1993) by raising them in such a way that the hospital cannot meet those expectations and thus receives lower ratings. Another possibility is that espousing compassion raises patient expectations in such a way that compassion is an expectation of the service experience rather than an aspect of care that exceeds service expectations. This too would explain lower scores or scores that are not in the "top-box."

Another interesting possibility is how this result may be similar to the findings in Cha's research (Cha and Edmondson 2006). Espousing compassion may also increase the likelihood of employee values expansion, perceptions of leader hypocrisy, or employee disenchantment. These outcomes may potentially have negative consequences for patient satisfaction scores and perceptions of care experiences too because of how these outcomes affect employees even when controlling for the presence of compassion routines. This suggests that hospital administrators may be better served by structuring to support compassion but not making claims in the organizational mission to do so for either their patients or their workforce. This is a question worthy of future inquiry.

The second set of interesting findings relates to the differential effects of the hiring and support compassion routine types on the two measures of patient satisfaction. First, hiring routines were positively related to patient ratings of the hospital. This finding suggests that selecting the “right” people (people who are likely to show compassion) into the organization predicts higher patient ratings of the hospital. This result is consistent with previous Person-Organization fit research which finds relationships between fit and increased prosocial behavior as well as fit and lower reported levels of stress (Kristof 1996). Both increased prosocial behavior and lower reported stress may collectively impact the service experience and in turn its evaluation. Employees who fit well are more likely to display these valued behaviors towards patients and families. Lower stress also enables these employees to be at their best. These factors should impact the quality of care provided in a service encounter. This would be reflected in individual patient ratings of the care experience. Organizations with high levels of fit would expect high aggregated ratings of the hospital as well. This finding held for both the samples of non-nursing and nursing executives. This shows the importance of hiring individuals into the workplace who are likely to display compassion regardless of whether they are frontline or back office workers. Interestingly, support routines, which are organizational responses to suffering, had different effects on the measures of patient satisfaction.

Instead, the use of support routines was associated with a greater likelihood that patients would recommend the hospital to a family member or friend for both sub-samples. While this finding supports the general logic that compassion routines should impact patient satisfaction, it also reveals the complexities in understanding how different routines impact a variety of service quality measures in different ways. Given the

importance of word-of-mouth and customer referrals (Winston 1988) in growing a business as well as maintaining market share (Reichheld 2003), support routines may play an important and strategic role for hospitals that compete in markets with other care providers for the same patient pool. The use of the hiring routines on the other hand may have a more direct effect on the financial viability of the organization because hiring routines shape HCAHPS ratings scores which will soon be tied to Medicare reimbursement rates. A potentially interesting question that future scholarship should consider is whether these compassion hiring routines predict the financial performance of hospitals once Medicare begins to tie HCAHPS scores to reimbursements rates. If this causal relationship could be demonstrated, then hospitals with a predominantly Medicare patient population would be well advised to focus attention on the kind of people they hire into their organization not only in direct care positions but support and administrative positions as well.

Another finding of interest is the effect of support routines on both HCAHPS measures for the nursing executive sub-sample. Because previous research has shown that the nursing care experience is a significant predictor in patient satisfaction and other measures of patient perceptions of care quality (Sitzia and Wood 1997; Kadner 1994; Blanchard et al. 1990), the role of support routines for nursing staff may be of critical importance to healthcare organizations. The empirical findings suggest that hiring the “right” nurses and attending to their suffering through compassion support routines, is a means by which the organization can shape the care experience and evaluations of care quality. For practitioners, this suggests that administrators should first focus on the use of

these compassion hiring and support routines within the nursing arm of the organization before extending their usage beyond this professional domain.

Another interesting result is the non-significance of compassion rewards routines on the HCAPHS measures. Previous scholarship has tied the alignment of rewards to desired behaviors (Lawler 1977, 1973, 1971), and things like expressions of gratitude to increased prosocial behavior (Grant and Gino 2010; Tsang 2006; Bartlett 2006). However, in this study, routines that recognize compassion do not seem to predict organizational outcomes like service quality regardless of whether or not compassion rewards are associated with greater displays of compassion. Given these findings, administrators interested in managing suffering and patient perceptions of care, should focus more on the use of compassion hiring and support routines rather than compassion rewards routines.

Finally, another important finding is the non-significance for all interaction variables. Despite the significant relationships between espoused compassion and patient satisfaction, as well as hiring routines and support routines with patient satisfaction, these constructs did not interact in such a way that the use of compassion routines influenced or dampened the negative effects of espousing compassion. This suggests that using hiring and support routines does not mitigate the negative effects of espousing compassion and more specifically they somehow do not intervene in shaping patient expectations of care quality. The routines may act as a conduit for compassion, but they do little or nothing to change initial patient expectations for compassion.

Theoretical Implications for Routines Research

One of the most interesting findings from the empirical study is how nursing executives responded differently to the hiring routines scale as a function of their role in the organization. In hospitals, nurses play a significant role at the bedside. The nature of nursing work and the kind of workplace suffering nurses commonly experience (i.e. burnout, compassion fatigue), may shape nurses' understanding of organizational routines in a way that differs from other professional groups. Ostensive aspects of routines within a single organization may vary between nursing and non-nursing functions because of the differences in the way these professional groups work and the different forms of suffering they experience.

While many scholars have thought of routines as an organization-level construct, in complex organizations like hospitals which have very different and striking divisions amongst professional roles, scholars may be better served to study routines at a more micro level. Examining how routines vary across professional groups that perform different kinds of work within one organization may help routines scholars gain greater insight into understanding routines in complex organizations that have clear division amongst professional roles. It may also help routines scholars better understand routines that foster more discretionary forms of behavior such as compassion. This perspective aligns with Feldman and Pentland (2003), who view routines as patterns of performances that shape the ostensive characteristics of routines. This is not to say that compassion routines are not a valid organizational construct, but in large and complex organizations, scholars should also look inside the organization and study routine enactments and ostensive templates along different lines or professional divisions within an organization.

Other Practical Implications

From a practitioner's perspective, the implications of these findings suggest that structuring to manage employee suffering enhances customer service experiences. We see evidence of this in the hospitals selected in this study. The empirical findings that tie compassion routines to patient satisfaction also have significant financial implications for healthcare organizations as well. In light of Medicare reimbursement changes (Centers for Medicare & Medicaid Services 2011; Studer, Robinson, and Cook 2010), the switch to VBP means that hospitals that have better HCAHPS score will receive higher reimbursements for their Medicare patients. For healthcare administrators, finding ways to improve reimbursement is critical. Structuring to attend to suffering may be a means by which hospitals not only manage suffering and create more positive care experiences, but also improve financial viability. Administrators interested in improving patient satisfaction scores should begin to look at how well their hospital is managing the suffering of its workforce. The empirical results of this study bring to the forefront the question of whether or not hospitals are structuring to care for their caregivers, because the implications of not doing so may be quite significant.

Conclusions and Research Extensions

These findings suggest a number of possible research extensions in the following areas: the nature and consequences of compassion structures, longitudinal research opportunities, additional measure development and validation, and replicating this line of research in other industry domains.

Future scholarship should continue to examine how routines can and do support the expression of compassion, not only for healthcare organizations but service

organizations broadly. Although this study examined how routines could support the expression of compassion, this study did not measure whether or not these routines did actually facilitate such behaviors in the workplace. Future research should also examine whether the usage of compassion routines in the workplace is associated with greater levels of experienced workplace compassion. Similarly, this research argues that compassion routines are a means to mitigate workplace suffering, but little is known about whether or not these routines did indeed reduce suffering in the workplace. Future studies should test whether or not these routines do have an effect on workplace suffering. Scholars could examine aggregate levels of suffering such as burnout or compassion fatigue across a sample of organizations and how that relates to compassion routines usage. Another possible avenue of research could examine whether or not compassion routines mitigate the costly effects of suffering such as poor performance, lower productivity, turnover, or workplace violence and aggression.

Demonstrating causality of compassion routines on patient satisfaction and other organizational outcomes is another fruitful area of research. Because this study relied on cross-sectional rather than longitudinal data, this research is unable to show a causal relationship. More research is needed using longitudinal data to test the causality between compassion structures and organizational outcomes like patient satisfaction. While this research focused on just global measures of patient satisfaction, future research should also consider what other effects compassion routines or compassion structures generally speaking, have on other organizational outcomes. In healthcare organizations, clinical measures of quality of care are also critically important to the well-being of patients. If compassion routines enable employees to perform better or produce higher quality work,

future research should study and measure whether or not these routines predict clinical and process measures of care quality. For service organizations more broadly, other measures of service quality should also be examined.

Demonstrating causality outside of healthcare is also another possible research path. Findings that confirm these relationships in other organizations would be an important contribution towards demonstrating the generalizability of the effects of compassion routines in service organizations beyond healthcare. Possible industry domains worthy of further study include retail, hospitality, and tourism. Scholars should consider expanding this research to other organizations where high levels of suffering are also experienced due to the nature of the work. Such possibilities could include studying the use of compassion routines in organizations such as air traffic control towers, the military, police forces, fire stations, and in prisons.

Finally, compassion scholars interested in studying compassion at a more macro level should continue to explore not only compassion routines, but how other structures become vehicles for supporting the expression of compassion. This brings to the forefront the need to not only better understand organizational compassion and compassion structures, but also the need to better understand how to observe and measure them. Without the latter, we will continue to know very little about the effects of such constructs at this level of analysis.

In many ways, this dissertation ventures into uncharted waters in order to measure and test the effects of compassion routines. While the findings begin to show why compassion counts, this research also creates a host of unanswered questions about compassion structures, and compassion routines in particular. My hope is that this

research is the proverbial pebble that creates a ripple effect in these waters. Future scholarship is needed to broaden our understanding of the nature and consequences of structures that attempt to manage suffering in the workplace.

FIGURES

Figure 1: Theorized relationship between Espoused Compassion and Structures



Figure 2: Theorized relationship between Routines and Thought and Action

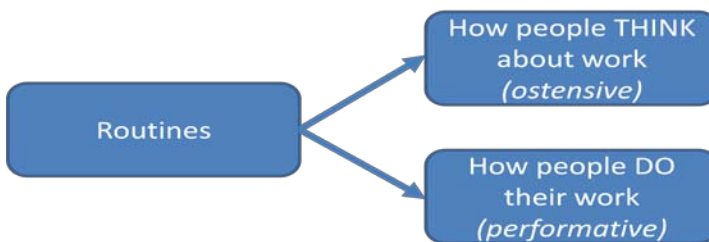


Figure 3: Theorized Relationship between Compassion Routines and Service Quality



Figure 4: Theorized Relationship between Espoused Compassion, Compassion Routines and Service Quality

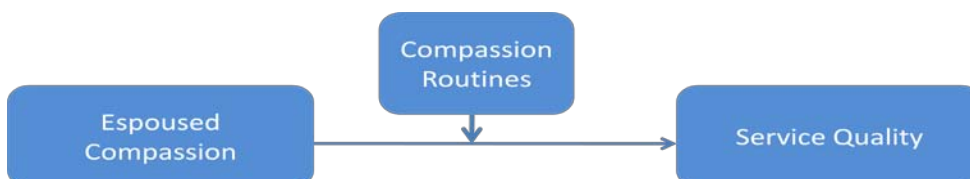


Figure 5: Hospital Signage**Figure 6: Comparison of Employee Support Routines at Alpha and Beta**

Routine Types	Definition	Alpha	Beta
Employee Support	Repeated ways that organizations provide support to help employees who are facing hardships or to improve employee well-being <i>Hardship, Sitting with the Dying, Employee Emotional Support, Support Interventions</i>	Emphasis on Tangible. Non-hardship routines less common in way participants understood routine	Emphasis on Tangible and Emotional/ Spiritual Support. Non-hardship routines described by many participants, data suggest enacted throughout organization

Figure 7: Comparison of Leadership Routines at Alpha and Beta

Routine Types	Definition	Alpha	Beta
Leadership	Repeated actions by senior leaders which facilitate noticing or response to suffering	Low Variety	High Variety Low Enactment

Figure 8: Comparison of Hiring Routines at Alpha and Beta

Routine Types	Definition	Alpha	Beta
Hiring	Repeated ways in which organizations select employees who are inclined to notice, feel, and respond to suffering of others	Nursing Less emphasis on compassion, more on PCC	Hospital Wide Empathy, mercy, compassion Qs

Figure 9: Comparison of Socialization Routines at Alpha and Beta

Routine Types	Definition	Alpha	Beta
Socialization	Repeated training that promotes, encourages, and routinizes noticing, feeling, and responding to the suffering of others <i>Perspective taking, Mission/Values Monitoring</i>	Care Transformation Office Driven Less emphasis on compassion, more on PCC Patient Involvement Increasing focus on mission monitoring enactment	Hospital Wide Emphasis on compassion No Patient Involvement Decline in enactment of mission monitoring

Figure 10: Comparison of Rewards Routines at Alpha and Beta

Routine Types	Definition	Alpha	Beta
Rewards	Repeated ways that recognize and reward acts of compassion <i>Awards, Recognition Cards</i>	Nursing, guest services, volunteer recipients Lack of clear recognition actions for compassion acts (exception Daisy award for RNs) Inconsistent use of cards	Hospital Wide Clear recognition actions, standardized Popular use of Angel cards, system integrated

Figure 11: Comparison of Communication Routines at Alpha and Beta

Routine Types	Definition	Alpha	Beta
Communication	Repeated use of hospital communication media to promote, encourage, or celebrate compassion	Less common Not widely acknowledged	More common Not widely acknowledged

Figure 12: Comparison of Spiritual Routines at Alpha and Beta

Routine Types	Definition	Alpha	Beta
Spiritual	Repeated reminder to attending to one’s own spiritual needs and the spiritual needs of others	Less common Less acknowledged	More common Variety Widely acknowledged

Figure 13: Role of Pilot Participants

Pilot Participants- By Role	%
Staff RN	45.5
Nursing Manager	17.8
Nurse Practitioner	17.8
Director of Nursing/CNO	18.9

Figure 14: Hospital Executives Demographics (Sample 3)

Participants Demographics		<i>Gender x Role[^]</i>			
CNO	38.20%	Gender	CNO	CHRO	COO/CEO
CHRO	24.70%	M	17	56	132
COO/CEO	37.10%	F	203	85	80
Average Tenure	13.25 yrs	[^] 6 did not report gender			
		Overall % Female		64%	

TABLES

Table 1: Routine type definition and mapping of qualitative data onto generated items

Routine Type, Definition, # items	Example of Qualitative Data Supporting Definition	Sample of generated items refined by qual. Data
<p>Hiring: 4 items These routines relate to the hiring process. They are ways that hospitals screen applicants for fit. Hospitals use these routines to assess the likelihood that applicants will show compassion at work. Examples include the use of behavioral interviewing to assess compassion and empathy tendencies.</p>	<p>We do behavioral based questions like “tell me about a time when you had somebody you felt like really needed somebody to listen and what you did to make them feel like somebody was.”</p>	<p>How often do hiring personnel discuss the importance of helping others during job interviews?</p>
<p>Socialization: 7 items Regular ways to encourage and remind both new and existing members of the organization to engage in compassion behaviors at work. Examples of this type of routine include perspective taking and mission/values monitoring.</p>	<p>So I ask them, "Take yourself back to that time when you felt like you had no control over anything. Remember that every time you have an interaction with a patient. That is probably what they are feeling like or even more so."</p>	<p>How often do hiring personnel ask questions about empathy during job interviews? (e.g. “Describe a time when you put yourself in the position of a colleague to decide what to do.”)</p>
<p>Employee Support: 6 items These routines are repeated patterns of action that attempt to provide support to employees experiencing suffering related to personal issues and/or workplace problems. These routines attempt to provide two forms of support—(1) employee emotional support or (2) tangible hardship assistance.</p>	<p>“We have a program where people can give paid time off days to other people, we have a program where people can donate money and we have a fund that’s available for other employees who are having hardship.”</p>	<p>To what extent does the hospital support employee hardship programs or benefits such as loans, grants, emergency funds?</p>
<p>Rewards: 4 items Regular patterns of actions that recognize or reward the expression of compassion at work using organizational artifacts—recognition cards and formal awards</p>	<p>“They get a big banner for the Daisy Award... It’s really a compassion award. The person went out of their way...did things that went beyond the standard of care that most nurses would do.”</p>	<p>To what extent does the hospital have compassionate caregiver/employee award programs (e.g. DAISY Award, awards for Clinical Staff, awards for Support Staff)?</p>
<p>Communication: 4 items Repeated use of communication media to promote, encourage, or celebrate compassion. This routine is performed using newsletters, email, signage etc.</p>	<p>“We have a board out here where we recognize folk for what their accomplishments and acts of faith is what I call it.”</p>	<p>To what extent do public display boards/walls showcase acts of caring?</p>
<p>Leadership: 4 items These routines facilitate leaders noticing the suffering of employees or create opportunities for empathetic concern for employees. Examples include shadowing and feedback.</p>	<p>“I am going to put scrubs on and shadow someone all day, so that is how I have built that in.”</p>	<p>To what extent do organizational leaders work alongside staff during a normal work day (e.g. rounds, shadowing)</p>
<p>Patient Care: 4 items Repeated ways in which the hospital fostered compassion towards patients and</p>	<p>“Her husband has been here for 9 days. They came to the ER, and she hasn’t left ...they</p>	<p>Does the hospital assist visitors facing financial hardship as a result of their</p>

families. This routine is similar to employee support routines which provide hardship assistance, however the recipient is a patient/family.	had nothing. So, I was able to get some meal vouchers and I was able to get her some help with the parking too.	family member or loved one's hospital stay (e.g. discounted parking, charitable lodging, meals etc...)?
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Table 2: Pilot Test Exploratory Factor Analysis, Item Loadings and Cross Loadings[^]

	Factor 1: Promote Promotion of compassion behaviors in the workplace	Factor 2: Recognition Public recognition of compassion, compassion acts	Factor 3: Emotional/ Spiritual Spiritual and emotional response to suffering, attention to spiritual/ emotional needs	Factor 4: Tangible Support Tangible and benefit-like forms of compassionate resources, responses
HR2	0.552	0.075	0.133	0.004
HR3	0.477	0.009	0.265	0.029
HR4	0.63	0.127	0.164	-0.122
SOC2	0.813	-0.095	-0.004	0.05
SOC3	0.429	0.21	-0.007	0.095
SOC5	0.426	0.211	-0.222	0.243
SOC6	0.817	0.036	-0.097	0.021
LDR2	0.521	0.161	0.076	-0.171
RW1	-0.007	0.787	-0.12	0.152
RW2	0.188	0.672	-0.05	-0.02
RW3	-0.234	0.555	0.428	-0.055
RW4	0.101	0.467	0.352	-0.065
COM1	0.131	0.579	0.079	-0.083
COM2	0.112	0.607	-0.052	0.035
COM4	0.319	0.391	-0.002	0.007
LDR3	-0.153	0.243	0.435	0.211
LDR4	0.159	-0.014	0.77	-0.114
ESP4	0.074	-0.006	0.515	0.223
ESP5	0.356	-0.155	0.446	0.201
ESP6	-0.004	-0.049	0.882	-0.037
SOC7	0.238	-0.099	0.072	0.574
ESP2	-0.107	0.058	-0.042	0.911
ESP3	-0.091	0.131	0.333	0.354
PC3	0.211	0.011	0.205	0.301

[^] All eigenvalues > 1.

Table 3: Loadings of Indicator Variables and Reliability

Construct	Indicator	Loadings	Mean	SD	Cronbach's Alpha
Promotion of compassion behaviors in the workplace	HR2	.552	4.67	1.730	.875
	HR3	.477	3.47	1.945	
	HR4	.630	3.65	1.838	
	SOC2	.813	4.42	1.741	
	SOC3	.429	2.92	1.677	
	SOC5	.426	5.21	1.659	
	SOC6	.817	4.11	1.755	
	LDR2	.521	2.68	1.787	
Public recognition of compassion, compassion acts	RW1	.787	5.13	1.713	.859
	RW2	.672	4.04	1.945	
	RW3	.555	5.19	1.863	
	RW4	.467	3.92	1.890	
	COM1	.579	4.54	1.846	
	COM2	.607	4.13	1.971	
	COM4	.391	<i>dropped</i>	<i>dropped</i>	
Spiritual and emotional response to suffering, attention to spiritual/emotional needs	LDR3	.435	4.71	1.933	.847
	LDR4	.770	4.15	1.935	
	ESP4	.515	4.28	2.036	
	ESP5	.446	3.84	1.966	
	ESP6	.882	4.88	1.925	
Tangible and benefit-like forms of compassionate resources, responses	SOC7	.574	5.22	1.706	.763
	ESP2	.911	5.23	1.640	
	ESP3	.354	4.91	1.972	
	PC3	.301	4.10	1.957	

[^] All eigenvalues > 1.

Table 4: Scales Used for Executive Survey

Label	Factor1: Promotes compassion in the workplace	
PROM1	E: Does the hospital promote a culture of caring in its hiring practices?	
PROM2	O: Do hiring personnel ask questions about empathy during job interviews? (e.g. "Describe a time when you put yourself in the position of a colleague to decide what to do.")	
PROM3	O: Do hiring personnel discuss the importance of helping others during job interviews?	
PROM4	E: Does new hire orientation training emphasize the importance of compassion amongst all staff in the hospital?	
PROM5	E: Do ongoing training programs discuss noticing fellow employees who are suffering (e.g. showing signs burnout, grieving over a loss, illness, family issues etc)?	
PROM6	E: Are employees/volunteers reminded to look out for patients and visitors who appear lost?	
PROM7	E: Does new hire orientation emphasize employees "putting themselves in the shoes of patients/family members?"	
PROM8	E: Do organizational leaders work alongside staff during a normal work day (e.g. rounds, shadowing)?	
REC5	E: Does the hospital use communication media (e.g. newsletters, email) reminding employees to celebrate everyday good deeds?	
REC6	E: Does the hospital environment (e.g. décor, artwork, signage, furnishings etc...) emphasize compassion?	
	Factor 2: Public recognition of compassion, compassion acts	
REC1	E: Does the hospital use recognition programs to reward employees for acts of caring shown to patients/families?	
REC2	E: Does the hospital use recognition programs to reward employees for helping one another?	
REC3	E: Does the hospital have compassionate caregiver/employee award programs (e.g. DAISY Award, awards for Clinical Staff, awards for Support Staff)?	
REC7	O: Do hospital leaders publicly celebrate acts of caring?	
REC4	E: Do public display boards/walls showcase acts of caring?	
	Factor 3: Employee Support -tangible support and emotional/spiritual support	
TAN1	E: Does new hire orientation discuss support resources such as counseling, or employee assistance programs that are available to employees?	
TAN2	E: Does the hospital offer regular programs that provide support or counseling for employees?	
TAN3	E: Does the hospital support employee hardship programs or benefits such as loans and grants, emergency funds?	^
TAN4	E: Does the hospital assist visitors facing financial hardship as a result of their family member or loved one's hospital stay (e.g. discounted parking, charitable lodging, meals etc...)?	
TAN6	E: Does the hospital organize acts of giving such as vacation donation programs for employees facing hardship?	#
EMO1	E: Does the hospital offer regular programs that provide pastoral care for employees?	
EMO2	O: Does your hospital facilitate support sessions for departments/units dealing with things like crisis events, conflict, trauma, or workplace stress?	
EMO3	O: Does your hospital facilitate grief rituals (e.g. memorial services) when learning of the death of an employee?	
EMO4	E: Do senior leaders host face-to-face forums where employees can voice concerns?	
EMO5	O: Do senior leaders participate in grief rituals in the hospital (i.e. memorial services, vigils etc)?	
EMO6	E: Is pastoral care or counseling available to patients/families immediately upon experiencing a crisis or trauma (e.g. day, evening, weekend shifts)?	**
<p><i>Note: "E" preceding questions uses the No Extent-Great Extent scale (To what extent...), "O" preceding the question denotes the item uses the "NEVER-ALWAYS" scale. (How often does...)</i></p> <p><i>^: Question reworded based on qualitative feedback and further analysis of pilot data, split apart</i></p> <p><i>** : Question re-worded in order to measure variance in routine. Original wording produced no variance and factor did not load. Expert panel agreed to retain item upon wording changes.</i></p> <p><i># : Question created from related question .</i></p> <p>Items in bold are final items retained for instrument and tested in Ch.4</p>		

Table 5: Initial Factor Loadings for Healthcare Executives: Loadings and Cross Loadings[^]

	Factor 1: Employee Support	Factor 2: Promote [^]	Factor 3: Reward
TAN2	.512	-.046	.163
TAN3	.423	.131	-.036
TAN6	.383	.097	-.065
TAN1	.485	.115	.127
TAN4	.554	.081	-.102
EMO1	.727	-.093	.040
EMO6	.671	-.160	.029
EMO3	.756	-.062	-.026
EMO2	.640	.038	.115
EMO5	.612	.157	-.069
PROM4	-.043	.701	.018
PROM8	.014	.490	-.023
PROM5	.290	.504	-.072
PROM7	-.205	.836	.026
PROM6	-.065	.550	.093
PROM2	.142	.555	.123
PROM3	.148	.694	-.091
REC5	.063	.394	<u>.208</u>
REC6	<u>.261</u>	.444	-.047
REC1	-.115	.036	.877
REC2	.011	.167	.636
REC3	.126	-.089	.790

[^]All eigenvalues > 1

Table 6: Revised EFA Run: Loadings and Cross Loadings

	HIRING [^]	REWARD	SUPPORT
PROM4	.618	.064	-.033
PROM7	.742	.073	-.163
PROM2	.593	.106	.160
PROM3	.861	-.162	.094
REC1	-.022	.901	-.089
REC2	.118	.636	.050
REC3	-.045	.771	.109
EMO1	.047	.070	.550
EMO2	.100	.102	.590
EMO3	-.114	-.068	.906

[^]Revised factor name based on re-examination of retained items, all eigenvalues > 1.

Table 7: Loadings of Indicator Variables, Cronbach's Alpha, AVE, Composite Reliability

Construct	Indicator	Loading	Mean	SD	Cronbach's Alpha	AVE	CR	SqrtAVE
Recruitment and Onboarding (HIRING)	PROM4	.618	4.63	1.612	0.81	0.506	0.8	0.71
	PROM7	.742	4.92	1.548				
	PROM2	.593	5.92	1.304				
	PROM3	.861	5.49	1.502				
Rewards (REWARDS)	REC1	.901	5.79	1.373	0.819	0.603	0.817	0.78
	REC2	.636	5.15	1.707				
	REC3	.771	5.39	1.865				
Employee Support (SUPPORT)	EMO1	.550	4.64	2.049	0.742	0.49	0.732	0.70
	EMO2	.590	5.35	1.585				
	EMO3	.906	5.06	1.814				

Table 8: Inter-construct correlations with square-root of AVE on diagonal

	Hiring	Reward	Support
Hiring	<u>0.71</u>	0.60	0.63
Reward	0.60	<u>0.78</u>	0.60
Support	0.63	0.60	<u>0.70</u>

Table 9: Correlation Table and Descriptive Statistics

Correlations ^a (SS1, AGGREGATE)														
Variable	Mean	s.d.	1	2	3	4	5	6	7	8	9	10	11	12
1. RUCA	2.77	2.36												
2. MAGNET	0.09	0.29	-.212**											
3. TEACH	0.84	0.37	-.114	.124*										
4. SIZE	233.46	187.13	-.527**	.449**	.213**									
5. RELIGIOUS	0.11	0.32	-.147*	.015	.086	.129*								
6. PROFIT	0.14	0.35	-.025	-.121*	-.242**	-.134*	-.150*							
7. RATING	65.87	8.07	.048	.124*	.008	.009	.163**	-.244**						
8. RECOMMEND	68.35	9.00	-.152*	.187**	.102	.186**	.186**	-.303**	.904**					
9. COMP_d	-0.01	1.00	-.123*	-.056	-.047	.020	.204**	.059	-.138*	-.093				
10. REWARD	16.02	4.24	-.337**	.169**	.040	.232**	-.007	-.008	.042	.147*	.006			
11. SUPPORT	14.77	4.59	-.355**	.175**	.182**	.332**	.176**	-.186**	.160**	.292**	.041	.530**		
12. HIRE_agg	20.01	5.09	-.176**	-.002	.023	.065	-.013	-.034	.150*	.181**	.006	.510**	.522**	
* p < .05														
** p < .01														
N=275 ^a														
Correlations ^a (SS2, Nursing)														
Variable	Mean	s.d.	1	2	3	4	5	6	7	8	9	10	11	12
1. RUCA	2.65	2.29												
2. MAGNET	0.09	0.29	-.193**											
3. TEACH	0.81	0.39	-.119	.136*										
4. SIZE	237.05	186.44	-.544**	.420**	.262**									
5. RELIGIOUS	0.14	0.35	-.135*	-.112	.074	.038								
6. PROFIT	0.12	0.33	-.058	-.079	-.303**	-.181**	-.144*							
7. RATING	66.45	7.61	.023	.178**	-.011	.078	.100	-.089						
8. RECOMMEND	69.13	8.58	-.205**	.239**	.076	.257**	.109	-.124	.889**					
9. COMP_d	0.02	1.00	-.087	-.012	.071	.032	.272**	-.102	-.040	-.001				
10. REWARD_n	16.50	4.04	-.357**	.146*	.069	.196**	-.041	-.009	.020	.081	-.045			
11. SUPPORT_n	15.32	4.12	-.325**	.196**	.272**	.321**	.171*	-.242**	.161*	.236**	.085	.528**		
12. HIRE_n	21.59	4.30	-.077	.064	.084	.087	-.012	-.081	.157*	.138*	.011	.511**	.491**	
* p < .05														
** p < .01														
N=213 ^a														

Table 10: Regression Results (Espoused Compassion Dichotomous Measure)

Variables	DV= RATING SS1-aggregate		DV= RATING SS2-nurses		DV= RECOMMEND SS1-aggregate		DV=RECOMMEND SS2-nurses		
	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	
Controls:									
RUCA	0.11	.110	0.10	0.10	-0.02	-0.02	-0.10	-0.09	
Magnet	0.14 **	.140 **	0.19 **	0.19 **	0.11 *	0.12 *	0.18 **	0.18 **	
Teach	-0.05	-.060	-0.06	-0.07	0.00	-0.01	-0.02	-0.03	
Size	-0.06	-.060	0.03	0.05	0.02	0.02	0.10	0.12	
Religious	0.17 ***	.170 ***	0.13 *	0.12	0.14 **	0.13 **	0.09	0.08	
Profit	-0.19 *	-.190 *	-0.01	-0.01	-0.23 ***	-0.24 ***	-0.04	-0.04	
Predictors:									
Comp_d	-0.15 **	-.150 **	-0.07	-0.07	-0.12 **	-0.12 **	-0.05	-0.04	
Reward	-0.03	-.030	-0.13	-0.15	0.00	0.01	-0.14	-0.16 *	
Support	0.11	.100	0.17 *	0.18 *	0.16 **	0.15 **	0.17 *	0.18 **	
Hire	0.15 **	.150 **	0.14 *	0.15 *	0.09	0.10	0.09	0.11	
Reward x Comp_d		.000		-0.08		-0.04		-0.09	
Support x Comp_d		.010		0.05		0.04		0.11	
Hire x Comp_d		-.070		0.04		-0.06		0.01	
ΔR^2		-0.01		-0.01		0.00		0.00	
adj. R ²	0.13	0.12		0.05	0.00	0.00	0.11	0.11	
F	5.02 ***	3.93 ***	**	1.95 **	0.00 ***	0.00 ***	0.00 ***	0.00 ***	
n	274	274		212	274	274	212	212	
*Standardized coefficients are reported									
* p < .10									
** p < .05									
*** p < .01									
Note: Espoused compassion measure is dichotomous									
DV's transformed using arc-sine root transformation									

Table 11: Regression Results (Espoused Compassion Ratio Measure)

	DV= RATING SS1-aggregate		DV= RATING SS2-nurses		DV= RECOMMEND SS1-aggregate		DV=RECOMMEND SS2-nurses	
Variables	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Controls:								
RUCA	0.13 *	0.13 *	0.11	0.12	-0.01	-0.01	-0.09	-.088
Magnet	0.14 **	0.13 **	0.19 **	0.18 **	0.12 *	0.11 *	0.18 **	.167 **
Teach	-0.04	-0.03	-0.06	-0.07	0.00	0.01	-0.02	-.030
Size	-0.05	-0.05	0.04	0.06	0.03	0.02	0.11	.123
Religious	0.15 **	0.15 **	0.12	0.10	0.12 **	0.12 **	0.08	.062
Profit	-0.19 ***	-0.19 ***	0.01	0.01	-0.23 ***	-0.23 ***	-0.02	-.023
Predictors:								
Comp_ratio	-0.10	0.04	-0.06	-0.07	-0.06	-0.09	0.01	-.004
Reward	-0.05	-0.04	-0.12	-0.15	0.00	0.00	-0.13	-.160 *
Support	0.09	0.10	0.17 *	0.19 **	0.15 **	0.15 *	0.17 *	.190 **
Hire	0.17 **	0.16 **	0.14 *	0.16 *	0.11	0.11	0.10	.118
Reward x Comp_ratio		-0.05		-0.20		-0.07		-.208
Support x Comp_ratio		-0.16		0.07		0.02		.072
Hire x Comp_ratio		0.02		0.15		0.02		.136
ΔR^2		-0.01		0.00		-0.01		0.00
adj. R ²	0.11	0.11	0.06	0.06	0.15	0.15	0.10	.100
F	4.45 ***	3.50	2.34 **	1.98 **	5.89 ***	4.59	3.37 ***	2.780 ***
n	274.00	274.00	212.00	212.00	274.00	274.00	212.00	212
aStandardized coefficients are reported								
* p < .10								
** p < .05								
*** p < .01								
Note: Espoused Compassion measure is the ratio measure root transformation								

APPENDIX

Appendix I: Interview Protocol

1. So tell me a little about what you do at the Hospital...
2. How would you define compassion?
3. What would you say makes this hospital a compassionate place to work?
4. Imagine you were starting your own hospital that you wanted to be compassionate. What would you do in this new hospital to make sure compassion happened?
5. Imagine you were trying to get rid of compassion in the hospital, what would you take away or destroy?
6. Do you try to assess if applicants will be compassionate on the job?
7. How are employees expected to show compassion to patients and their families?
8. Tell me how any training that employees receive discusses ways employees can make a patient and their family's experience easier?
9. Tell me about a time when an employee went out of his/her way to help a patient's family?
10. What about the hospital's environment reminds you to be compassionate?
11. Can you describe the little things the hospital does to make your job easier?
12. Tell me about a time when the hospital cared for one "of its own?" Was anyone recognized for this, how?
13. Can you tell me about a time when senior management showed compassion?
14. How about a time when senior management showed a lack of compassion?
15. How does the organization help employees who have lost a loved one?
16. Has there ever been a time when you were under a lot of strain at work? Was anyone compassionate toward you?
17. Can you remember a time when you received something like an email that made you aware of things like support-drives or other efforts to help fellow employees?
18. Tell me about a typical newsletter (if any) that employees receive, is compassion discussed, celebrated, encouraged?

Appendix II: Types of Participants in Field Study

Chief Human Resource Officer/ VP of Human Resources
Director of Guest Services/ VP of Hospitality Services
Director of Food Services
Director of Nursing
Chief Nursing Officer
Director of Patient Advocacy
Chief Mission officer
Sister/Nun
Director of Mission Integrations
Nurse Tech
Hospitality Assistant
RN
Chief of Staff/Chief Medical Officer
Oncologist
Endocrinologist
Chief Quality Officer
Chief Operating Officer
Director of Ethics
Director of Marketing
Director of Nutrition
Director of Transportation and Environmental Services
Director of Staff Support
Director of Pastoral Care
Transporter
Director of Palliative Care
Director of Case Management
Human Resources Generalist
Human Resources Recruiter
Director of Care Transformation
Administrative Assistant, Care Transformation
Director of Education and Organizational Development
Director of Volunteering and Auxiliary

Appendix III: Non- participant Observation Protocol

As I observe work during the work day or during evening shifts, these are things to note and describe fully.

All observations are non-participant observations at Alpha/Beta Hospital. As I observe these work routines, these are things to note and describe fully when the organization grants permission to do so.

Hiring Routines: Focus on observing interviewer, and how she conducts interview, the content she discusses related to expected behaviors, and kinds of behavioral interviewing techniques used (if at all) that relate to compassion. Not recording information about content of applicant responses, applicant questions.

Training Routines: Focus on observing formal trainers during new hire orientation/training to better understand content of training that relates to expected behaviors, and how that content is delivered. Informal Training focuses on observing helping and compassion behaviors on the job performed by employees of that unit as evidence of role-modeling during on-the-job training within a given unit/department.

Rewards Routines:

Formal Rewards: Focus on artifacts that the organization uses to formally recognize employees for being compassionate, helping, and what kinds of behaviors are rewarded. Observation is in public spaces and involves noticing use of “comment cards” or “nominate a star employee for X....,” Pictures/plaques recognizing employees for certain behaviors are just some examples.

Informal Rewards focuses on observing informal recognition or rewards given to employees on-the-job, focus on observing all employees during a shift and looking for small acts like praise, what is content of praise, what was praise for? Will perform in units/departments with department/unit permission.

Communication Routines: Observe ALPHA/ BETA use of email, intranet, internet, and other hospital-wide communications, and newsletters that discuss compassion, helping. ALPHA/BETA use refers to communications sent to employees on behalf of the organization, thus focus is on artifacts on display in public spaces, newsletters distributed.

Support Routines:

Informal Support: Look for acts of helping between co-workers in a given unit to help manage work load/stress etc.

Formal Support: Observation of formal support groups and what facilitator discusses about ways to get help, and support available for hospital (i.e. discussion of employee assistance programs, counseling, pastoral services). Will also look for artifacts related to formal support programs (brochures about work stress etc...), and logistics of support availability (i.e. location of programs/groups, convenience, frequency etc).

Appendix IV: Locations/Types of Non-Participant Observations in Field Study

Cafeteria: Line, Cashiers

Coffee stand

Waiting Rooms

CCU Family Rooms

Hospitality Assistant Shifts

Crisis Management (Discharge Planning)

New Hire Orientation

Frontline Staff award ceremonies

Schwartz Rounds©

Bedside Shift Report Training/ Patient-Family Advisor Program

Bedside Shift Report status meeting

Appendix V: Coding Table of Routines

TYPE	Routine	Description	Example
SUPPORT	Philanthropic Annual Giving to targeted recipients	These are philanthropic/giving routines that are organized efforts involving multiple individuals that are either organized/ sponsored by the hospital. Recipients of giving are either members of the hospital and their families or families in the general community. The identity of the recipient/family is known, and the collection efforts are done for the recipient in order to help them in their unique hardship circumstances. Help may include the giving of money, gifts, meals for example. ^r	Ex: "So, at Christmas time, our staff said we are going to adopt our co-worker for our Xmas project, rather than someone we don't know. So they collected money for toys, they bought toys for the little 3 year old, they bought a big Xmas dinner food, got a bunch of cash, I say they probably gave her \$900."
SUPPORT	General Employee Hardship Giving	Efforts involving multiple individuals that are organized or supported by the organization in order to help those employees who are facing hardship. Employee contributions go into a general pool of resources that the organization administers, and the organization distributes to recipients on a case by case basis, confidentially. Organization may also facilitate direct giving through donation structures. Examples include hardship funds, PTO/ Vacation donation fund. Recipients request assistance. ^r	Ex: "We have a program where people can give paid time off days to other people, we have a program where people can donate money and we have a fund that's available for other employees who are having hardship."
SUPPORT	Support Intervention	Support sessions that facilitate discussions on stress management or dealing with traumatic events, allow venting. ^{o,r}	Ex. "I will say to them, can we pull your staff together, and can we have opportunity for them to vent, can we have an opportunity to release whatever emotions they are experiencing."
SUPPORT	Counseling	Support sessions for individual employees through counseling/pastoral support in order to discuss personal issues, stress, hardship, traumatic events with the intent of helping/relieve suffering. ^r	Ex. Our program, staff support is not the only program. Faculty staff assistance is just down the street, I have a really good working relationship with Faculty Staff, so when staff come in here, and it's clear they need much more than my expertise, I am on the phone with person in my office calling Faculty Staff and if I need to drive them down, I drive them down..."
SUPPORT	Grief Rituals	Regular use of hospital resources to host grief rituals often related to death of patients, employees, spouses, community tragedies etc.	Ex. "If I lose a staff, their children or whoever will be invited in to go to the memorial service here, had a very pretty service up in the chapel for one of our cafeteria ladies who passed away. She had been sick, she got on disability, but another department had a pianist who plays beautifully and he sings and he came and gave his time, do a couple songs and play here in the

			service, so you know we all work together.”
TRAINING/ SOCIALIZATION	Perspective taking	As part of new hire and OTJ training, employees are asked to “put themselves in the shoes of the patient/family member” or imagine it was their family member up there.” This kind of training facilitates empathy and perspective taking as a way to be more aware of patient/family member suffering, and the causes of suffering and perhaps ways to respond to alleviate such suffering. ^{o,r}	Ex. So I ask them, “You have to have a time when you felt vulnerable, take yourself back to that time when you felt like you had no control over anything. Remember that every time you have an interaction with a patient; that is probably what they are feeling like or even more so.”
TRAINING/ SOCIALIZATION	Employee Support Training	Organized training sessions that educate employees on burnout/compassion fatigue, stress signs to look for in self, co-workers, and the kinds of resources available to provide support to those in need. ^{o,r}	Ex. “Some of it is awareness, crisis awareness, if you see these 3 things, these three things could be occurring, and our FSAP helps us with trying to be more aware. Right now it's a matter of trying to identify who needs it.”
TRAINING/ SOCIALIZATION	Orienting Routine	Staff/ volunteers are taught and reminded of the challenges of navigating a hospital facility and to look for patients/families who appear lost or in need of assistance and to ask them if they need help etc. ^o	Ex. “Everybody's pretty clear on the expectation, so if you are walking down the hallway, and you see a patient or family who looks lost that you stop and you ask them, are you lost, would you like me to help you carry that bag?”
COMMUNICATION	Use of public displays related to compassion	Systematic use of public display areas (i.e. recognition boards to showcase/highlight “acts of compassion/ helping shown in hospital). ^{o,r}	Ex. “We have a board out here where we recognize folk for what their accomplishments and acts of faith is what I call it.”
COMMUNICATION	Celebration Reminders	Reminders using communication media to remind and celebrate everyday acts of compassion and helping. Enactment may also empower staff to celebrate the small stuff/ victories/ good deeds in a way that is meaningful and relevant to them/their area. ^r	Ex. “They just haven't done it in the past, so it's not top of mind. Celebrations are for my supervisor to decide, versus I just feel like having a little celebration for my co-workers because I think they did a bang up job yesterday. So, it's not that they don't want to, they just haven't practiced it. It's something we need to practice.”
COMMUNICATION	Caring Décor, Signage	Use of imagery throughout hospital, hospital campaigns that convey messages of compassion in caregiving. ^{o,r}	
COMMUNICATION	Use of Relational/ Behavioral Agreements	Systematic practice of creating an agreement or compact initiated and created by the staff for the staff about how employees are expected to work, behave, and what behaviors won't be tolerated. This practice is often facilitated by unit manager or outside staff person like head of staff support, or HR or pastoral services,	Ex. “The covenant is going to be for people who comprise the team around surgical services, how are we going to, what are you going to agree to in terms of, what you can expect from me, in my relationship, what I can expect from you, what we can expect from patients and families, how are we going to define who we are as a

		and staff sign agreement and it is visually displayed in unit. ^r	community, and that's , it's going to be focused on behavior, it's going to be focused on behavior, it's going to enhance our ability to be compassionate with each other as coworkers and with patients and families as members of the team, and it's really cool!"
REWARDS	Awards	Use of formal awards in the hospital to recognize acts of compassion, being compassionate at work. Award can be for frontline or back office, employees, staff, volunteers, physicians. (Ex: Daisy Program for Nursing) ^{o,r}	Ex. "Then they get a big banner for the Daisy Award, then they have a little speech and they get recognized for that. It's really a compassionate award. The person went out of their way to be sure they got a haircut, when nobody was around they gave the haircut themselves...just they went out and got food for them, they made them a milkshake, they did things that went beyond the standard of care that most nurses would do."
REWARDS	Recognition card	Program where patients/families/employees in the hospital can recognize other employees or volunteers for showing compassion on the spot using cards/nomination forms. Card/nomination forms often placed throughout the hospital and organization members collect , review cards and provide positive feedback to nominee. ^{o,r}	Ex. "It's been around forever. It's our homegrown recognition tool. This is the way family members, patients, anyone can recognize a staff member, physician or volunteer for something they did. These are all around the hospital, in boxes, every patient floor has one, outpatient areas, and also online. That's important because that's often how employees fill them out. You fill it out, it goes into the computer system and then goes to the manager and says one of your employees has received a card. I read them out loud during staff meetings, honor people, recognize people. Once they reach a certain number of cards they receive a pin, a caught by an Angel pin. People wear these with pride, people love them."
HIRING	Behavioral Interviewing	Training and use of system-wide interview questions that ask behavioral questions to assess likelihood of behaving empathetically, compassionately on the job to patients/families and to co-workers. ^r	Ex. "We do behavioral based questions like "tell me about a time when you had somebody you felt like really needed somebody to listen and what you did to make them feel like somebody was..."
HIRING	Promote culture of caring	Promotion of a culture of caring, compassion and empathy of the organization's culture or mission during hiring and on-boarding as a means to attract applicants and signal valued behaviors. ^r	Ex. "I ask them what's led them to us... do they bring up the mission, the values, that we are a faith-based organization?"
LEADERSHIP	Shadowing	Regular practice of leaders shadowing hospital employees during a normal work day/shift in order to better understand	Ex. "I am going to put scrubs on and shadow someone all day, so that is how I have built that in."

		employee roles, problems, stresses, resource needs.	
LEADERSHIP	Feedback Forums	Regular opportunity to provide face-to-face feedback to sr. leaders in organization about problems or concerns within the hospital. ^r	Ex. "The second week I was here, <i>our CEO</i> has a monthly luncheon where a random selection of 20 people are invited to come, a sandwich lunch. And he asks questions, 'what's going on, what's the gossip around here, tell me what the deal is, tell me what needs to happen?'"
SPIRITUAL	Spiritual Reminding	Regular practice that draws attention and reminds members to practice compassion at work. ^{o,r}	Ex. "The evening prayer, it just sets the tone no matter how busy the night."
PATIENT CARE	Palliative Care- Education, Patient Management	Regular practice of providing holistic care that focuses on symptom, pain and stress management from serious illness in order to help improve quality of life and attend to patient suffering.	Ex. "Getting them in touch with appropriate resources like hospice when it's appropriate or maybe saying "now's not the time for hospice and here's why..." But just so that they have a roadmap of how to move through."
PATIENT CARE	Patient/ Family Hardship	Regular ways of providing financial assistance to families facing hardship as a result of their loved one's stay (meal vouchers, lodging, parking vouchers). ^{o,r}	Ex. "I had a woman referred to me, her husband has been here for 9 days and they came to the ER, and she hasn't left. When she realized that it was going to be \$5.00 a day [to park], she doesn't have that money. They had nothing. So, I was able to get some meal vouchers and get her some help with the parking too."
PATIENT CARE	Bedside Shift Reporting	Regular RN practice of providing a detailed face-to-face report, at the bedside, of each patient's status at the end of a shift to the RN who is coming on duty. ^{o,r}	Ex. "We talk to the families when they first come in. We let them know we do bedside shift report and they are invited. They can come ...whenever we are doing it, and know they can participate."

All coding categories were derived from semi structured interview; "o" indicates supplemented with observations; "r" indicates supplemented with archival data.

Appendix VI: Variation in Routines between Alpha and Beta

Routine Types	Definition	Alpha	Beta
Employee Support	Repeated ways that organizations provide support to help employees who are facing hardships or to improve employee well-being	Emphasis on Tangible. Non-hardship routines less common/legitimate	Emphasis on Tangible and Emotional/ Spiritual Support. Non-hardship routines enacted throughout organization
Leadership	Repeated actions by senior leaders which facilitate noticing or response to suffering	Low Variety	High Variety, Low Enactment
Communication	Repeated use of hospital communications to promote, encourage, or celebrate compassion	Rare	Multiple media, many examples in data
Hiring	Repeated ways in which organizations select employees who are inclined to notice, feel, and respond to the suffering of others	Nursing	Hospital Wide
Socialization	Repeated training that promotes, encourage, and routinize noticing, feeling, and responding to the suffering of others	Low variety, less legitimate	High variety, legitimate
Rewards	Repeated ways that recognize and reward acts of compassion	Nursing, Volunteer, Guest Services	Hospital Wide
Spiritual	Repeated ways that reminded employees of the spiritual needs and suffering of others and themselves	Less common/less awareness	Hospital Wide/ well-understood

Appendix VII: Converted Labels between Sample 2 and Sample 3/ Revised 3 Factor Solution

Factor1:	Hiring and On-boarding Routines that promote compassion in the workplace	
PROM1-HR2	E: Does the hospital promote a culture of caring in its hiring practices?	
PROM2-HR3	O: Do hiring personnel ask questions about empathy during job interviews? (e.g. "Describe a time when you put yourself in the position of a colleague to decide what to do.")?	
PROM3-HR4	O: Do hiring personnel discuss the importance of helping others during job interviews?	
PROM4-SOC2	E: Does new hire orientation training emphasize the importance of compassion amongst all staff in the hospital?	
PROM5-SOC3	E: Do ongoing training programs discuss noticing fellow employees who are suffering (e.g. showing signs burnout, grieving over a loss, illness, family issues etc)?	
PROM6-SOC5	E: Are employees/volunteers reminded to look out for patients and visitors who appear lost?	
PROM7-SOC6	E: Does new hire orientation emphasize employees "putting themselves in the shoes of patients/family members?"	
PROM8-LDR2	E: Do organizational leaders work alongside staff during a normal work day (e.g. rounds, shadowing)	
REC5-COM2	E: Does the hospital use communication media (e.g. newsletters, email) reminding employees to celebrate everyday good deeds?	^
REC6-COM4	E: Does the hospital environment (e.g. décor, artwork, signage, furnishings etc...) emphasize compassion?	^
Factor2:	Recognition of compassion acts routines	
REC1-RW1	E: Does the hospital use recognition programs to reward employees for acts of caring shown to patients/families?	
REC2-RW2	E: Does the hospital use recognition programs to reward employees for helping one another?	
REC3-RW3	E: Does the hospital have compassionate caregiver/employee award programs (e.g. DAISY Award, awards for Clinical Staff, awards for Support Staff)?	
REC7-RW4*	O: Do hospital leaders publicly celebrate acts of caring?	
REC4-COM1	E: Do public display boards/walls showcase acts of caring?	
Factor3:	Employee Support Routines	
TAN1-SOC7	E: Does new hire orientation discuss support resources such as counseling, or employee assistance programs that are available to employees?	
TAN2-ESP2	E: Does the hospital offer regular programs that provide support or counseling for employees?	
TAN3-ESP3	E: Does the hospital support employee hardship programs or benefits such as loans, grants, emergency funds?	
TAN4-PC3	E: Does the hospital assist visitors facing financial hardship as a result of their family member or loved one's hospital stay (e.g. discounted parking, charitable lodging, meals etc...)?	
TAN6-ESP1*	E: Does the hospital organize acts of giving such as vacation donation programs for employees facing hardship?	
EMO1-ESP4	E: Does the hospital offer regular programs that provide pastoral care for employees?	
EMO2-ESP5	O: Does your hospital facilitate support sessions for departments/units dealing with things like crisis events, conflict, trauma, or workplace stress?	
EMO3-ESP6	O: Does your hospital facilitate grief rituals (e.g. memorial services) when learning of the death of a hospital employee?	

EMO4-LDR3	E: Do senior leaders host face-to-face forums where employees can voice concerns?	
EMO5<-LDR4	O: Do senior leaders participate in grief rituals in the hospital (i.e. memorial services, vigils etc)?	
EMO6<-PC2*	E: Is pastoral care or counseling available to patients/families immediately upon experiencing a crisis or trauma (e.g. day, evening, weekend shifts)?	
Notes: ^Items moved from Factor 1 to Factor 2 between pilot and second test. Loadings were low, thus items subsequently dropped. *Reworded items based on panel feedback. Bold items are the final retained items used in subsequent analysis.		

Appendix VIII: Items retained per factor

Factor 1: Hiring Routines that promotes compassion in the workplace

1. How often do hiring personnel ask questions about empathy during job interviews? (e.g. "Describe a time when you put yourself in the position of a colleague to decide what to do.")?
2. How often do hiring personnel discuss the importance of helping others during job interviews?
3. To what extent does new hire orientation training emphasize the importance of compassion amongst all staff in the hospital?
4. To what extent does new hire orientation emphasize employees "putting themselves in the shoes of patients/family members?"

Factor 2: Public recognition of compassion, compassion acts routines

1. To what extent does the hospital use recognition programs to reward employees for acts of caring shown to patients/families?
2. To what extent does the hospital use recognition programs to reward employees for helping one another?
3. To what extent does the hospital have compassionate caregiver/employee award programs (e.g. DAISY Award, awards for Clinical Staff, awards for Support Staff)?

Factor 3: Employee Support

1. To what extent does the hospital offer regular programs that provide pastoral care for employees?
2. How often does your hospital facilitate support sessions for departments/units dealing with things like crisis events, conflict, trauma, or workplace stress?
3. How often does your hospital facilitate grief rituals (e.g. memorial services) when learning of the death of a hospital employee?

Appendix IX: Survey Layout

GENERAL INSTRUCTIONS

This survey is intended to explore and measure variation in hospital routines. It is intended to be completed from the perspective of how your organization generally operates.

Although there are a wide variety of questions asked about your hospital, the survey should take less than 10 minutes to complete.

PLEASE NOTE THAT ALL RESPONSES ARE CONFIDENTIAL

If you find a question to be ambiguous or confusing, please give a response according to your best interpretation of the question. Thank you for completing this questionnaire. We appreciate your time and effort!

Please select the response that most accurately describes your hospital.

If you do not know an answer, please leave answer blank.

IN THIS HOSPITAL, TO WHAT EXTENT...

No
Extent Great
Extent

1. Does the hospital offer regular programs that provide support or counseling for employees? 1 2 3 4 5 6 7

2. Does the hospital promote a culture of caring in its hiring practices? 1 2 3 4 5 6 7

3. Does the hospital use communication media (e.g. newsletters, email, etc.) reminding employees to celebrate everyday good deeds? 1 2 3 4 5 6 7

4. Does the hospital support employee hardship programs or benefits such as loans, grants, emergency funds? 1 2 3 4 5 6 7

5. Does new hire orientation training emphasize the importance of compassion amongst all staff in the hospital? 1 2 3 4 5 6 7

6. Do organizational leaders work alongside staff during a normal work day (e.g. rounds, shadowing, etc.)? 1 2 3 4 5 6 7

7. Does the hospital use recognition programs to reward employees for acts of caring shown to patients/families? 1 2 3 4 5 6 7

8. Do public display boards/walls showcase acts of caring? 1 2 3 4 5 6 7

Next 

Please select the response that most accurately describes your hospital.

If you do not know an answer, please leave answer blank.

IN THIS HOSPITAL, TO WHAT EXTENT...

- | | No | Extent | Great |
|--|----|--------|-------|
| | 1 | 2 | 3 |
| 9. Do training programs remind employees/ volunteers to look out for patients/visitors who appear lost? | 1 | 2 | 3 |
| 10. Does the hospital organize acts of giving such as vacation donation programs for employees facing hardship? | 1 | 2 | 3 |
| 11. Do training programs discuss noticing fellow employees who are suffering (e.g. showing signs of burnout, grief over a loss, illness, family issues, etc.)? | 1 | 2 | 3 |
| 12. Do senior leaders host face-to-face forums where employees can voice concerns? | 1 | 2 | 3 |
| 13. Does the hospital use recognition programs to reward employees for helping one another? | 1 | 2 | 3 |
| 14. Does new hire orientation emphasize employees "putting themselves in the shoes of patients/ family members?" | 1 | 2 | 3 |
| 15. Does the hospital offer regular programs that provide pastoral care for employees? | 1 | 2 | 3 |

4

Please select the response that most accurately describes your hospital.

If you do not know an answer, please leave answer blank.

IN THIS HOSPITAL, TO WHAT EXTENT...

- | | No | Extent | Great |
|--|----|--------|-------|
| | 1 | 2 | 3 |
| 16. Does the hospital environment (e.g. decor, artwork, signage, furnishings, etc.) celebrate compassion? | 1 | 2 | 3 |
| 17. Is pastoral care or counseling available to patients/ families immediately upon experiencing a crisis or trauma? (e.g. day, evening, weekend shifts)? | 1 | 2 | 3 |
| 18. Does new hire orientation discuss resources such as counseling, or employee assistance programs that are available to employees? | 1 | 2 | 3 |
| 19. Does the hospital have formal recognition or rewards for compassionate caregiver/employees (e.g. DAISY award, Support Staff awards, Clinical Staff awards)? | 1 | 2 | 3 |
| 20. Does the hospital assist visitors facing financial hardship as a result of their loved one's hospital stay (e.g. discounted parking, charitable lodging, meals, etc.)? | 1 | 2 | 3 |

5



For the next set of questions, please select the response below that most accurately describes how often this occurs in your hospital.
If you do not know the answer, please leave answer blank.

IN THIS HOSPITAL, HOW OFTEN...

Never

Always

21. Does your hospital facilitate grief rituals (e.g. memorial services) when learning of the death of a hospital employee? 1 2 3 4 5 6 7
22. Do hospital leaders celebrate employee acts of caring? 1 2 3 4 5 6 7
23. Do hiring personnel ask questions about empathy during job interviews? (e.g. "Describe a time when you put yourself in the position of a colleague to decide what to do?") 1 2 3 4 5 6 7
24. Does your hospital facilitate support sessions for departments/units dealing with things like crisis events, conflict, trauma, or workplace stress? 1 2 3 4 5 6 7
25. Do hiring personnel discuss the importance of helping others during job interviews? 1 2 3 4 5 6 7
26. Do senior leaders participate in grief rituals in the hospital (i.e. memorial services, vigils, etc.)? 1 2 3 4 5 6 7

27. Please use the section below to provide any comments on the survey...
 (Is there anything additional you would like to share about one of the questions above? Are there other practices that you feel contribute to a culture of high quality of caring?)

6

28. Select the title that most accurately describes your role in the hospital:

- Chief Nursing Officer/ VP of Nursing/Director of Nursing
- Chief Human Resource Officer/ VP of Human Resources/ Director of HR
- Chief Operating Officer
- President/ CEO/ Hospital Administrator
- Other _____

29. Gender: Male Female

30. How long have you worked for this organization? _____ years _____ months

31. Your Hospital's Name: _____

32. Select the description which best describes your hospital:

- General Acute Care Hospital
- Cancer Hospital
- Children's Hospital
- Critical Access Hospital
- Psychiatric Hospital
- Rehabilitation/Long-Term Care Hospital
- Specialty Hospital (i.e. Orthopedic Hospital, Spine Hospital, Eye Hospital)
- Other _____

33. To receive a summary report of the study's findings, select one option below...

- YES! Send it to the mailing address on file.
- YES! Send it to a different address:
 Address: _____
 City/State/Zip: _____
- YES! Send it to this email address: _____
- NO. Please do not send a summary report.



Thank you very much for your generous participation in this study!

7

Appendix X: HCAHPS Items**RATING**

Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

Scale (0-10)

RECOMMEND

Would you recommend this hospital to your friends and family?

Definitely No

Probably No

Probably Yes

Definitely Yes

Source: (HCAHPS Hospital Care Quality Information for the Consumer Perspective 2011)

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