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Nurses' Compassionate Care in Pediatric Oncology: An Ethnographic Study

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Abstract

Background: Compassion is a crucial element in assisting children with cancer and their families in dealing with the physical, emotional, and social challenges of cancer. However, it is a multidimensional concept that is influenced by the cultural beliefs of each society. The purpose of this study was to determine the compassionate behaviors of Iranian nurses in caring for children with cancer.

Methods: This study was conducted using a focused ethnographic approach. The participants included all nurses, children hospitalized in the oncology department, and their motherss. Data were collected through observations, formal and informal interviews, and evaluation of documents. A total of 220 hours of formal and informal observation and interviews were conducted over 12 months. This study was carried out after the approval of the ethics committee.

Results: The results of this study were extracted in the form of three cultural themes of kindness arising from dependence (emerging from verbal communication, non-verbal interactions), presence (emerging from physical presence, continuous care, and technological communication),

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and beyond professional communication (emerging from the mother as the second client, becoming a substitute for a child's friend, and involving the child in care).
Conclusion: In conclusion, it can be said that compassionate care in pediatric oncology is not static and has evolved by embracing changes in communication methods to maintain its dynamism. In addition, religious beliefs may be a contextual influence shaping compassionate care behaviors.
Keywords: Compassionate care, Nursing, Pediatric, Oncology, Palliative care

Introduction

Cancer is the second leading cause of death in children, with an estimated incidence of 178 per million in American children. The cure rate is over 80% in developed countries but less than 20% in less developed countries.[1] Iran, the sixth-highest country in Asia for cancer prevalence,[2] is experiencing a rise in childhood cancer cases. According to Hashemi's,[3] analysis in 2024, the standardized cancer incidence rate increased from 129.2 per million in 1999 to 132.3 per million in 2016.

Children with cancer suffer from a wide range of symptoms and side effects from the disease and treatment, which negatively impact their quality of life and that of their families. Therefore, they require comprehensive care that addresses their specific needs.[4] Snaman et al[5] emphasizes that children are not simply small adults; they differ in many ways, including their developmental levels, decision-making capacities, and cognitive skills. Communicating with children about illness, treatment, and death must take these differences into account.

Compassion plays a crucial role in providing excellent care for children with cancer[6] and responding to their pain and suffering. It is considered a fundamental aspect of patient care and contributes to enhancing patient dignity.[7, 8] Compassionate care can also enhance satisfaction with the healthcare system by improving the overall quality of care.[9]

Compassion plays a crucial role in providing excellent care for children with cancer [6] and in responding to their pain and suffering. It is considered a fundamental aspect of patient care that enhances patient dignity[7, 8] and it can also improve satisfaction with the healthcare system by raising the overall quality of care. [9]

Despite its importance, compassion is often conflated with related concepts. In the literature, it shows its closest semantic affinity to sympathy and empathy. Sympathy, however, is an emotional reaction to the misfortune of others, and empathy is the ability to understand others' feelings and respond in a manner appropriate to their emotional state. Compassion, by contrast, literally means "to suffer with" another and refers to a deep awareness of another person's suffering coupled with a desire to relieve it. [10]

Studies have been conducted in the area of compassionate care in pediatric oncology. For example, Ghaljeh et al[6] focused on humane and end-of-life considerations in pediatric oncology,

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emphasizing attention to cultural context and family values. Sinclair et al[7] presented a model for providing compassionate care in pediatric oncology. However, Sinclair et al8 criticized studies of compassionate care in clinical settings for being limited to conceptualization and attempting to provide models of compassionate care without considering actual practices. Compassion is based on action and requires observing people's behavior in the real world. Nevertheless, a crucial question arises: how do nurses actually enact compassion at the bedside when caring for children with cancer, what specific behaviors manifest this compassion, and what values guide these actions? To bridge this gap and elucidate what actually occurs in clinical reality, a focused ethnographic approach was employed to explore how compassionate care is enacted in pediatric oncology units.

Compassion, as a human concept of care, is influenced by cultural diversity.[9] The cultural context of societies guides how compassion is expressed, defined, and practiced within different norms, values, and cultural traditions.[11] Therefore, it is essential to conduct studies across different cultures to identify the behaviors that healthcare providers exhibit in compassionate care in clinical settings within diverse cultural contexts. To address this question, a focused ethnographic approach is appropriate because it centers on a specific research question, observes individuals' behaviors in real-world settings, and unlike other methods does not rely solely on interviews.

This study aimed to explore how nurses enact compassionate care in everyday practice when caring for children with cancer within the Iranian cultural context

Materials and Methods

This study utilized the ethnographic method with a focused approach. Spradley's[12] methods were employed for observations and interviews. The interpretive paradigm guided the research towards a deeper understanding of the social system. Ethnography enables researchers to observe real behavior in natural settings rather than relying solely on verbal expressions.

Participants and Research Context

The research was conducted in the pediatric oncology department of a hospital in the second most populous city in Iran. The city's main source of income is religious tourism. The hospital is the primary pediatric treatment center in the city, serving as the only government facility for children with cancer in the east and northeast regions of Iran. Patients from neighboring cities and provinces seek treatment at this center, which admits children up to 18 years old for cancer treatment and related complications. The ward accommodates children with various types of cancer requiring chemotherapy, with a majority diagnosed with leukemia. The section has 35 active beds, with 5 to 6 beds per room based on available space. Due to limited space, two rooms have one and two beds, respectively. Each shift is staffed with 6 nurses, one of whom is in charge, while the others provide care to the children. Mothers have chairs next to their children's beds, which can be converted into beds for overnight stays. Additionally, there are two bathrooms available for mothers and children in the section.

In ethnography, key informants are individuals from whom the ethnographer gathers the most information about a culture.[13] This study included 4 oncologists, 27 nurses, 4 nursing assistants, 5

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pediatric residents, and one family caregiver who provided care for the children. These participants were caregivers for the children under study.

Data collection and analysis

The observation, documentation, and semi-structured interviews were used to collect data. Ethnographers aim to achieve an emic perspective. From the onset of entering the research environment, participant observation was utilized as the primary method of data collection by the first author. Through participant observation, the researcher gains a sense of localization in the social environment by participating in roles and experiencing socio-cultural dynamics. Participation in care activities such as teaching patients, monitoring children, recording tests and graphs, in addition to gaining the trust of the actors, allowed for the observation and consideration of behaviors among the individuals involved in the research. The researcher observed how nurses demonstrate compassion for children and families through caring behaviors, such as communication with the child/family and their reactions to expressions of suffering. The observations began descriptively and then became more concentrated and selective during various morning, evening, and night shifts. The first author is a pediatric oncology nurse with 4 years of clinical experience and a nursing student instructor. She entered the ward as a PhD student and held no formal clinical responsibilities during data collection. At the beginning of fieldwork, nurses and other actors in the field asked about the reason for her presence; she explained that she was conducting research for her doctoral dissertation and clarified her role and the study aims. Although she had no formal duties, she occasionally participated informally in ward activities, such as assisting with venipuncture. This participation occurred mainly at the beginning of fieldwork and aimed to build trust with the actors in the research setting. Her clinical experience facilitated the process of building trust and gave her an understanding of the ward's routines. However, this familiarity may also have influenced what participants said or did in her presence (e.g., social desirability) and led her to take certain clinical practices for granted during interpretation. Given her prolonged engagement in the field (220 hours of observation over 12 months), this influence was likely reduced over time as participants became accustomed to her presence. Short notes were taken during observations and expanded upon at the earliest opportunity. Formal and informal interviews were conducted during or after observations to clarify and further explore the findings.

From September 2021 to August 2022, a total of 220 hours of participant observation and formal and informal interviews were conducted to collect data**.** During observation, the researcher interacted with the ward's clinical staff (4 oncologists, 27 nurses, 4 nursing assistants, and 5 pediatric residents) and with mothers and other family caregivers. Informal conversations with these individuals were recorded as field notes. To supplement the observation data, formal interviews were conducted with 12 nurses and 8 mothers of hospitalized children who served as key informants**.** Participants were selected through purposive sampling with maximum variation histories of the child's illness, places of residence, and education levels (for mothers), as well as different work backgrounds and presence in the oncology department (for nurses). Inclusion criteria were willingness to participate in the study and the ability to communicate their

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experiences. The researcher approached potential participants in person on the ward, in coordination with the head nurse, explained the study aims, and invited them to participate. Sampling continued until data adequacy was reached; therefore, the number of interviewees was determined by information richness rather than by the total number of ward personnel, and not all eligible staff were interviewed. No eligible individual declined or withdrew. T Semi-structured interviews lasted between 45 minutes to 1 hour.

Formal interviews were initially conducted in the head nurse's room. However, after conducting two interviews, the researcher realized that the mothers did not feel comfortable being present and talking in this space. Therefore, the interview location was changed with the mothers' coordination, and the interviews were conducted in a different room during hours when the classroom was not active.

Sample interview questions included: How do you demonstrate compassion to the child/family? How do you support the child/family with emotional and social problems? How do you respond when the child/family discusses their suffering with you? What tone does the nurse use when communicating with the child/family? How can you tell if a healthcare provider is compassionate? (Parent interview). To further clarify the interviews, questions such as "Could you elaborate on...?" or "What did you mean by...?" were asked. Finally, participants were asked, "Is there anything else you would like to share?" or "Feel free to contact me if you have anything else to add".Informal interviews were conducted immediately or shortly after the observations to clarify the observations .The researcher engaged in informal interviews with individuals present at the event by observing activities that aligned with the research objective. These interviews began with questions like "I noticed you were doing... today, could you explain more about that?" This was followed by inquiries such as "What does this behavior signify to you? Why did you act in this manner?" to uncover the values and beliefs of the individuals present at the event. Based on the responses and data provided by the participant, the interview proceeded with further clarifying and probing questions like "Can you elaborate on this... What is the significance of this...? Please provide more details". All interviews were recorded with the participants' consent. Observations were promptly documented. The researcher recorded her reflections to mitigate potential biases. Data collection and analysis were conducted concurrently, and the field notes and interview transcripts were reviewed by the first author under the supervision of the research team. Data adequacy was judged to have been reached when no new themes or subthemes emerged and the data confirmed the existing categories, indicating that the research questions had been adequately addressed.[14] Specifically, no new subthemes emerged in the last interviews with nurses and mothers only reiterated existing categories. Likewise, observations across different shifts and situations (e.g., [procedures, medication rounds, night shifts]) showed recurring patterns, and informal conversations in the field no longer added substantially new information. The analytic sample comprised field notes from observations and informal conversations together with the transcripts of the 20 formal interviews.

The Miles & Huberman[15] approach was utilized to manage and analyze the data obtained from the fieldwork. In this study, the Carney Ladder of Analysis Abstraction recommended by Miles &

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Huberman[14, 16] was employed for data analysis, which involves three general steps. The first step involves data summarization through data transcription and identifying primary codes. The second step focuses on identifying relationships within the data and uncovering themes. The third step involves confirming the identified relationships through cross-checking the findings.

Data analysis began with an inductive approach concurrent with data collection. After each fieldwork session, the collected data were transcribed into text and a contact summary sheet was completed for each day of observations. According to Miles & Huberman,[14, 15] the contact summary sheet serves as a reflection on the main themes and concepts observed during the contact, guiding further data collection and analysis. The contact summary sheet addresses questions such as the main themes observed, central research questions, new hypotheses, and areas for future focus. In qualitative analysis, the goal is to interpret findings at a higher level than initial compilation, necessitating immersion in the data. Observations, field notes, and interviews were read multiple times post-transcription, and data condensation was carried out by generating a list of descriptive codes. Similar phrases were identified, and descriptive codes were organized into reduced descriptive codes, leading to a list of key events providing comprehensive descriptions of the observations. The researcher then sought to identify relationships between the findings through within-case and cross-case analysis. Common quotes and observations related to a concept were grouped together in within-case analysis to identify pattern codes. Cross-case analysis of pattern codes was then conducted to identify cultural themes. Finally, the identified themes were examined using various data sources to confirm them.[15]

Ensuring Trustworthiness

Credibility refers to the accuracy of reported findings and encompasses activities that are carried out correctly to enhance trustworthiness.[17] Ethnography involves prolonged observation of individuals in their natural environment, interaction with them, and triangulation in data collection through observation, interviews, and document reviews to ensure data credibility. Peer checks were also utilized to bolster the credibility of the data. Throughout the research process, supervisors who are experts in qualitative studies monitored the research progress. The coded data obtained from participants was shared with them for member checks to validate that the findings accurately reflected their experiences.

Dependability is established when the researcher demonstrates the validity of the findings.[16] For audit purposes, the entire research process, from inception to completion, is meticulously detailed in the article. Additionally, all field observation notebooks and conversation recordings were retained to verify the dependability of the study.

Conformability assesses the consistency of research findings with the objectives and ensures they are not influenced by the researcher's personal opinions or beliefs.[16] A portion of the research findings was reviewed by experts in ethnography to externally validate the data collection and analysis process. Reflection allows the researcher to acknowledge their own values and recognize how these may impact their research and practices, with the goal of minimizing their influence on the research process.[11] In this study, the researcher underwent an interview with a professional qualitative interviewer before entering the research field to identify her goals, biases, and

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expectations regarding compassionate care in a pediatric oncology ward. The audio recording of this interview was transcribed, and the concepts discussed were considered throughout the data collection and analysis stages. Additionally, the researcher continuously questioned how their values and beliefs might influence the research and documented these reflections.

Transferability pertains to the extent to which the data can be applied to similar situations and is achieved through detailed descriptions of the findings.[16] The first author provided comprehensive descriptions of nurses' behaviors and interactions with children's families and caregivers to ensure transferability.

Ethical Consideration

The study was approved by the Ethics Committee of Mashhad University of Medical Sciences (ethics code: IR.MUMS.NURSE.REC.1400.001). The researcher obtained permission from the institution (Mashhad University of Medical Sciences) and presented a letter of introduction to the research field officials before collecting data. Because participant observation was conducted in an open clinical setting, consent was obtained separately from each participant group. Ward staff were informed about the study aims and the researcher's role, and verbal consent was obtained from those whose practice was observed. Mothers and other family caregivers were likewise informed about the study, and verbal consent was obtained for the observation of their interactions in the ward. Children were not considered research participants; they were observed only as part of the naturally occurring interactions in the ward, and no data were collected directly from them. Because children were present in these interactions, verbal informed consent for their presence in the observed interactions was obtained from a parent or guardian. Observation focused on the behavior and practices of the staff and family caregivers involved in the children's care. Participants and parents were informed that they could decline or withdraw from observation at any time, and no data were recorded for individuals who declined. It is important to note that the interview location was chosen by the participant. Prior to the interviews, the research objectives, voluntary nature of participation, and audio recording were explained to the participants, who were then asked to sign a written informed consent form. Confidentiality was maintained by [using codes instead of names in field notes, audio files, transcripts, and reports, and storing the data securely; specify]. In ethnographic studies, ensuring participants' consent is crucial; accordingly, the procedures described above were applied throughout the fieldwork.

Results

The participants in this study included nurses, children, and family caregivers of children.

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Table 1. Characteristics of family caregivers of the child participating in the study

Code	Age	Child's diagnosis	Duration since child's diagnosis	Residence	Education level
Patient's attendant 1	30	ALL	2 years	City	elementary
Patient's attendant 2	23	ALL	14 months	Village	diploma
Patient's attendant 3	32	Brain Tumor	8 months	City	Master's degree
Patient's attendant 4	45	ALL	18 months	Village	Elementary
Patient's attendant 5	26	ALL	10months	city	Bachelor's degree
Patient's attendant 6	28	Brain Tumor	24 months	city	Bachelor's degree
Patient's attendant 7	21	ALL	8 months	City	Student
Patient's attendant 8	39	ALL	30 months	City	elementary

Table 2. Characteristics of medical personnel participating in the study

Code	Age	level of education	Job experience in hospital (Year)	Work Experience in Pediatric Oncology
Nurse1	53	Bachelor's Degree	18	12
Nurse2	50	Bachelor's Degree	16	15
Nurse3	48	Bachelor's Degree	15	10
Nurse4	27	Bachelor's Degree	5	3
Nurse5	30	Master's Degree	8	5
Nurse6	37	Bachelor's Degree	12	12
Nurse7	32	Bachelor's Degree	8	6
Nurse8	25	Bachelor's Degree	2	2
Nurse9	45	Master's Degree	23	20
Nurse10	52	Bachelor's Degree	29	18
Nurse11	35	Bachelor's Degree	10	8
Nurse12	38	Master's Degree	13	5

Data analysis yielded 895 descriptive codes, 25 reduced descriptive codes, and 8 pattern codes. Ultimately, three cultural themes emerged: 1) Kindness Arising from Dependence, 2) Presence, and 3) Beyond Professional Communication (see Table 3).

Table 3. Cultural themes and pattern codes emerging from data analysis

Cultural Theme	Pattern Code
Kindness grounded in emotional dependence	Verbal communication
	Non-verbal interactions
Presence	Physical presence
	Continuous care
	Technological communication
Beyond Professional Communication	Mother; second client
	Participation child in care
	Becoming a substitute for a child's friend

Theme 1: Kindness grounded in emotional dependence

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This cultural theme highlights the verbal and non-verbal acts of kindness that arise from the emotional attachment on children and mothers, particularly mothers. Observations have revealed that nurses exhibit these behaviors through genuine greetings, speaking in a soothing tone, using affectionate language in their interactions, sharing light-hearted moments, attending to crying and consoling mothers, often involving both the mother and child. The following field note and interview with a nurse provide evidence to support this observation:

" *At about ۹, The night shift nurse entered the patient's isolated room to take over from the evening nurse. Using a childlike voice, the nurse greeted the child with, "How are you, my duckling?" The child and his mother smiled. (Field note 10).*

In an informal interview, the nurse expressed, "In this ward, we form emotional bonds with these children. As they are chronic patients who frequently return, we grow attached to them. We strive to keep them happy and avoid upsetting them. It's heart-wrenching to witness their physical deterioration over time, from their initial appearance with beautiful hair to becoming thin and pale. This motivates us to bring joy and humor into their lives" (Nurse No.5).

This exchange transformed a routine handover into a moment of warmth, indicating a personalized connection between the nurse and the child rather than a merely procedural one. This behavior appeared to be deliberate this behavior as deliberate, carried out consciously with the aim of reducing the child's suffering.

Non-verbal kindness was also expressed through playful interactions with the children, particularly during admission and discharge, such as hugs and handshakes. The following field note illustrates this:

"It was the evening shift. The nurse left the nursing station to administer the children's medications. As she reached the middle of the ward, one of the children, who was being discharged, told the nurse he was leaving. The nurse turned toward the child, bent down, and hugged him, saying, 'How wonderful that you're going home! Watch some cartoons for me too.' The child laughed and agreed." (Field note 3)

In effect, discharge was framed not as a merely administrative event but as a joyful experience for the child, reflecting the emotional attachment that the nurses described.

The mothers of the child also received non-verbal kind behaviors, such as smiling, making eye contact, and creating a supportive environment for emotional release (crying).

Nurses believe it is important to focus on the mother in critical situations, such as when facing a sick or deceased child, by being present beside her, touching her arms, holding her hand, helping her release emotions, and actively listening to her. The following field note provides an example of this pattern:

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" A mother was standing in the middle of the ward, quietly crying, as she talked with the nurse. The nurse placed her hand on the mother's arm and then took the mother's hand (field note 9)

When the researcher later asked about this interaction, the nurse explained:

"If you do everything perfectly for a child in terms of clinical care, but neglect the mother, act coldly towards her, ignore her, and don't show empathy, the mother needs emotional support. She wants to feel that someone is there for her, understanding her struggles. That's why I make sure to listen to the mothers so they can find some relief." (Nurse No.3).

From the nurses' perspective, then, emotional support for the mother was not an optional extra but a continuation of good care for the child.

Some observations have shown that teenage boys tend to exhibit more verbal expressions of affection rather than non-verbal gestures. It was noted that non-verbal behaviors like touching and hugging were less frequent when caring for this group of patients.

Theme 2: Presence

The essence of this cultural theme is the physical presence of nurses alongside the mother and child, dedicating time to them, and attentively observing and responding with awareness and expertise. This presence manifests in physical, continuous, and technological forms. Through observations, it is evident that nurses demonstrate their empathy towards the child and mother by being prepared and accessible to skillfully address their needs, which mothers perceive as attentive care and dedicated time for the child. The nurse's physical presence stems from understanding the unique needs of the child and mother, and the nurse endeavors to cater to the patient's requirements based on their individual circumstances to ensure a comfortable experience.

An interview arranged later, the nurse explained how her own experience of motherhood shaped her response to mother

> *At the beginning of the evening shift, a mother came to the nursing station and asked the shift supervisor to tell her the result of her child's blood test, which had been taken that morning. Despite the crowded files, the presence of the resident, and the nurses' questions to the supervisor, she first went to the computer system and read the result to the mother." (Field note 14])*

In an interview arranged at a suitable opportunity, the nurse explained how becoming a mother changed her response to mothers' anxiety:

> *"When I first came here, I didn't have a child yet. When a mother asked for a test result, I would shout, 'No, we don't give test results!' I couldn't understand why she was so worried. [...] After I had my own child, I understood what being a mother means. [...] Now I know how they feel, and I become more sensitive to their children's conditions. Here you can easily help them; you only need to understand them. There is a real difference between our nurses without children*

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and those with children. As a mother, I understand how valuable that child is to her." (Nurse *No. 12*)

The nurse's own experience of parenthood appeared to deepen her understanding of mothers' circumstances and feelings, and this understanding seemed to be reflected in her compassionate behavior toward them.

A mother expressed her satisfaction with the nurse by stating,

"I am content with my nurse because she is very compassionate, she devotes time to my child, she shows care towards him, she understands my concerns, and when she is looking after my son, I feel at ease knowing she responds promptly when her presence is required" (Mother No.6).

The nurse's proficiency in providing care is deemed essential for compassionate care, as mothers believe that a compassionate nurse possesses the necessary skills to care for a child. One mother articulated,

"When a nurse is compassionate, it matters how she administers needles and medications to a child; a nurse who lacks compassion neither understands nor seeks to acquire the requisite skills" (Mother No.12).

The presence of nurses alongside the mother and child extends beyond the child's stay in the ward. Even after the child is admitted or transferred to other wards, nurses continue to be present, monitoring their condition and alleviating their stress. One nurse expressed this sentiment by stating:

"*We don't just focus on the child's condition; it's about compassionate care. Whenever I hear that a patient has been admitted to the ICU, I make it a point to visit the mother because she is also going through a tough time and needs someone to comfort and listen to her." (Nurse No.8).*

Furthermore, post-discharge, nurses maintain their presence and support for the mother and child, even extending into the virtual realm through communication networks. This ongoing support aims to address any concerns the mother may have about caring for the child at home or staying connected with the child. A nurse shared her experience:

"*I encountered a family from another city who were anxious about interpreting test results after discharge. When the mother confided in me about their worries and desperation, I provided them with my phone number so they could send me the results. Upon reviewing the results and reassuring them, the family was overwhelmed with gratitude, and the patient even cried on the phone." (Nurse No.1).*

This form of presence transcends the child's lifetime, as nurses continue to offer support and comfort to mothers even after the child's passing. In the virtual space, nurses actively engage with mothers, providing emotional and spiritual support by attending to their conversations and needs.

Theme 3: Beyond Professional Communication

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This theme reflects compassionate nursing practices that extend beyond nurses' formal duties, characterized by informal, friendly interactions with patients that depart from traditional professional norms. The following field note illustrates this:

> *"The 8-year-old child often accompanies me to the bedside of other patients and even helps with preparing the medication by shaking the vials containing antibiotics on the table before I administer them. The child then puts the vials back on the trolley (observation 5). Regarding this, the nurse shared: When the child joins me for medication administration, it indicates a desire for communication. We strive to create a less intimidating environment for children in nursing care. While our interactions with the child usually involve procedures like vein cannulation or medication administration, showing him that we can be gentle and not cause harm builds trust over time. This approach helps reduce the child's anxiety during medical procedures and fosters a sense of trust in us." (Nurse No.5).*

In fact, the nurse sought to make the environment feel safer for the child by giving them a small role in the procedure, using this interaction to counter the child's association between nurses and painful procedures.

Another aspect of non-professional communication was observed in the interactions between nurses and mothers, which transcended formality and was characterized by a sense of friendship. One mother, highlighting the friendly rapport with nurses, contrasted the nurses in the oncology department with those in other departments, stating:

> "*I feel very at ease with the nurses here; they are friendly and have a good relationship with mothers. They explain everything they do for the child and answer my questions openly. In other departments, the nurses are different; they are guarded with families, uncommunicative, and inattentive." (Mother No.4).*

For mothers, nurses' informal interactions were not perceived as unprofessional; rather, they created an environment in which mothers felt comfortable asking questions.

Furthermore, a cultural aspect of communication beyond professional boundaries involved nurses assuming the role of a child's companion. When children experienced emotions like sadness or stress, nurses used games and drawing to alleviate these feelings. They engaged in play or drawing activities with the children, demonstrating compassionate behavior that deviated from traditional professional norms. Similar gestures of empathy were also extended to mothers, as nurses shared personal experiences with them. The following field note illustrates this:

> *"A nurse sat beside a 5-year-old child on the bed and, pointing to drawings on a whiteboard, said with a smile, "This is me. Would you like to draw yourself?" The child said that he wanted to draw his mother." (Field note 13).*
>
> *Reflecting on this interaction, the nurse said***:** *"This child was not speaking at all. I made efforts to engage with him, talking and joking, but he remained unresponsive. However, when I brought a whiteboard and markers, I drew and conversed with him, and he opened up to me. These*

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young children struggle to articulate their concerns verbally, so talking may not always be effective. It is crucial to empathize with their worries, identify their interests, and approach them in a way that brings comfort." (Nurse No.7)."

Here, the nurse used a form of communication suited to the child's cognitive level, replacing verbal dialogue with an alternative means of communication. Here, the nurse used a form of communication suited to the child's cognitive level, replacing verbal dialogue with an alternative means of communication.

Discussion

The aim of this study was to elucidate behaviors that demonstrate compassionate nursing care in the pediatric oncology department. The observations revealed instances of compassionate care through three cultural themes: Kindness grounded in emotional dependence, presence, and communication beyond professional boundaries.

The first cultural theme identified was Kindness grounded in emotional dependence, which was observed through both verbal and non-verbal behaviors. These behaviors included smiling, joking, hugging, and active listening. In this study, nurses frequently demonstrated kindness towards the child through their words. Goetz et al[9] also suggests that compassion can be effectively communicated through touch and tone. The use of non-verbal behaviors such as touch is essential for conveying compassion to the patient.[18] Additionally, the findings of a study by Burnard et al[19] suggest that Thai nurses express their affection through smiling and verbal communication.

The cultural context can significantly influence the expression and boundaries of compassionate non-verbal behaviors. Anthropologists suggest that cultures vary in their use of touch in communication, with Asian cultures relying more on facial expressions and tone of voice, while Western cultures often incorporate touch into their conversations.[19] One of the key observations in this study was the attachment that existed between nurses and children. Nurses stated that, because of the children's repeated and prolonged hospitalizations and the distress they felt at witnessing the children's suffering, they developed a psychological and emotional attachment to these children. Although this attachment may differ from definitions of attachment in the psychological literature, nurses themselves referred to it as attachment.

While some evidence describes nurses' emotional involvement with patients as undesirable due to the emotional stress it may impose[18] and its potential negative impact on nursing professionalism,[19] emotional attachment to the child acts as a catalyst for compassionate care. However, as Mikulince et al[20] suggest, attachment is associated with compassion and benevolence, whereas Taggart[21] views compassion as a product of attachment. Similarly, this study cannot definitively claim whether attachment gives rise to compassionate behaviors or compassionate behaviors lead to attachment.

The second cultural theme that emerged from the study was presence. Carter et al[22] consider compassionate care as a reconstruction of the concept of nurse presence. The results of the present study showed that two groups of hospitalized children and mothers (mostly mothers) are the target of receiving compassionate care, which is in line with the concept of palliative care that emphasizes the family's need for care just like the child.[5] This is seen as the moral duty of healthcare

providers.[23] Timely care and support for family caregivers are considered examples of compassionate care for oncology patients.[18, 24] Paying attention to the family in compassionate care aligns with the principle of not abandoning the family. [23] In this study, the nurses were present with the mothers in many situations, such as when the child was hospitalized in other departments. Even after the death of the child, they remained present by communicating through phone or online during the mourning stages.

The study by Sinclair et al[8] examines the emotional support provided by therapy professionals to families through virtual platforms as a form of compassionate care. The expansion of nurses' roles in offering psychological support to mothers can be analyzed from two perspectives. Firstly, it aims to transform the dynamics between healthcare providers and patients due to the increased use of social media, which, despite its drawbacks, has brought about positive changes in the relationships of oncology nurses. Secondly, one nurse explained that her own experience of motherhood deepened her understanding of mothers' circumstances and feelings and made her more sensitive in how she approached them. This suggests that personal experience of parenthood may shape how some nurses respond to mothers, although the present data do not allow us to determine the influence of gender or maternal identity.

The third cultural theme identified in the study goes beyond professional communication. Nurses establish a friendly rapport with the children through informal interactions. Sinclair et al[7] proposed a model for delivering compassionate care to pediatric cancer patients, highlighting how nurses may go beyond their clinical duties to address needs in a timely and unconventional manner, showcasing the humanistic aspect of compassion.

Compassion is nurtured through the therapeutic relationship and is expressed through both verbal and non-verbal communication.[25] Nurses' attentiveness to the child's age and adapting their interactions based on the child's level of understanding and needs is crucial. They demonstrate compassion more effortlessly to young children through simple gestures like using a playful tone and offering hugs. However, with teenagers, compassionate care is delivered through friendly interactions, considering the communication preferences of this age group. In this study, the female oncology nurses refrained from physical contact, such as hugging, with male adolescents while providing compassionate care. This behavior may reflect the cultural and religious norms governing interactions between genders in Iranian society.

This aligns with findings from Babaei et al[26] similarly reported that cultural and religious backgrounds can shape the provision of compassionate care, including gender-specific behaviors.

A notable observation in this study was that mothers linked compassionate care to nurses' clinical competence. Mothers regarded a nurse as compassionate when she responded promptly and skillfully to the child's needs. This finding is consistent with Fry et al[27] that compassionate care complements nurses' clinical competencies, enhancing their practical and professional nursing skills.; however, this view emerged mainly from mothers' accounts, and we cannot claim that clinical skill in itself constitutes a form of compassion toward the child.

One of the most significant limitations of the present study was the role conflict experienced by the primary researcher. Throughout the observation and fieldwork, the researcher grappled with a

conflict of roles, as the dual responsibilities of being a mother and a nurse influenced the researcher's ability to interpret the performance of the care team and child caregivers. At times, the researcher's role was overshadowed by her roles as a nurse and mother, leading to a potential bias in the interpretation of the data. To address this challenge, the researcher made a conscious effort to refocus on the research objectives by maintaining detailed journal notes and engaging in reflective practices. One limitation of this study was the researcher's prior relationship with the nurses from her years of work as a clinical nurse. This familiarity may have influenced what participants chose to say or do in her presence and her interpretation of their behavior. To limit this influence, in addition to the qualitative interview conducted at the beginning of the study, the researcher recorded her values and beliefs throughout the study and took them into account during data collection and analysis.

Furthermore, the study did not consider the experiences of other medical staff, such as male doctors and nurses, which could have provided a more comprehensive understanding of compassionate care in pediatric oncology. Future research should aim to explore the behaviors and perspectives of a diverse range of medical professionals to enrich the understanding of compassionate care in this context.

Another limitation of the study was the inability to access children in end-of-life care. These children were typically housed in specialized wards with restricted access, preventing the researcher from observing their behaviors and experiences. This limitation underscores the need for future studies to address the unique challenges and needs of children at the end of life in the context of compassionate care.

Conclusion

In this focused ethnographic study, compassionate care was expressed through kindness, sustained presence, and relational communication within the cultural and clinical context of a pediatric oncology setting. The findings suggest that cultural and religious norms may shape some expressions of compassionate care, particularly interpersonal communication and physical contact. These findings should be interpreted in light of the study setting and the researchers' positionality. The findings may inform pediatric oncology nursing education and reflective practice by illustrating how compassionate care can be enacted in everyday clinical interactions.

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Conflict of Interest

The authors declare no potential conflicts of interest related to the research, authorship, and publication of this article.

Data Accessibility

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

Ethical Issues

This study was approved by the ethics committee of Mashhad University of Medical Sciences under the code **IR.MUMS.NURSE.REC.1400.001.** Data collection commenced after obtaining permission from the Ethics Committee and presenting a letter of introduction to the relevant authorities. Informed consent was obtained from all participants, and the study was conducted in accordance with ethical guidelines and regulations.

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Research Highlights

What is the current knowledge?

- Compassionate care is an important component of pediatric oncology nursing.
- The expression of compassion may be shaped by cultural and clinical contexts.

What is new here?

- Compassionate care was expressed through kindness, sustained presence, and relational communication in a pediatric oncology setting.
- Repeated interactions with children and families appeared to facilitate nurses' emotional attachment and compassionate behaviors.
- Compassionate care extended beyond the child to include family caregivers and, in some cases, continued through communication after discharge.

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