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Compassion Fatigue in Healthcare: A Concept Analysis

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Abstract:

Compassion fatigue represents one of the most significant yet underrecognised occupational hazards confronting nurses and healthcare professionals. Despite growing empirical evidence linking it to diminished patient care quality, elevated medical error rates, and workforce attrition, it remains inconsistently defined and frequently conflated with closely related phenomena such as burnout and secondary traumatic stress. The analysis aimed to clarify the meaning of compassion fatigue through a structured concept analysis, differentiate it from related constructs, delineate its defining attributes, antecedents, and consequences, and establish a conceptual foundation for its application in nursing education, healthcare practice, and organisational policy. Walker and Avant's (2011) eight-step method of concept analysis was applied, drawing on peer-reviewed literature published between 1992 and 2025 sourced from PubMed, CINAHL, PsycINFO, and Scopus. Four defining attributes were identified: prolonged empathic exposure to others' suffering, emotional exhaustion and empathic numbing, secondary traumatic stress symptomatology, and functional and professional decline. The concept progresses through five recognisable phases. Antecedents include high empathic orientation, cumulative trauma exposure, inadequate organisational support, and insufficient individual coping resources. Consequences span individual psychological deterioration, compromised patient safety, and organisational dysfunction. Compassion fatigue is a distinct occupational phenomenon requiring systematic recognition and multi-level intervention. Addressing it effectively demands integrated action from healthcare organisations and individual practitioners to protect caregiver well-being and sustain safe, compassionate patient care.

Keywords: compassion fatigue, nurses; secondary traumatic stress, burnout, professional quality of life, nurse well-being,

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Introduction

Compassion fatigue is an emotional, physical and psychological state of exhaustion, caused by the ongoing exposure to patients' suffering and trauma, which causes a decreased level of empathy, care capability and professional distress (Garnett et al., 2023). It was first described by Joinson (1992) in a study on Burnout among Nurses; and he defined it as the price that caregivers pay as a result of caring for people suffering from pain. The concept has been later theorized in more precise terms by Figley (1995) as a type of secondary traumatic stress, which is the emotional, behavioural and cognitive aftertaste of exposure, not necessarily one's own experience of trauma, but rather the trauma of others to whom one is attached. Figley (2002) also described compassion fatigue as a condition of heightened stress, preoccupation and worry about the cumulative and individual distress of clients, with feelings of hopelessness, confusion and a loss of job meaning. The concept has spread to nursing, psychology, social work, emergency services and humanitarian work and there is now a significant body of empirical research which documents the prevalence, determinants, and consequences of Joinson's initial identification of the concept.

The amount of the issue is big. The results from the systematic review and meta-analysis by Xie et al. (2021) from 73 studies with more than 23,000 nurses suggest that prevalence of compassion fatigue is clinically significant and is affecting more than half of the world's nursing workforce. In a systematic review and meta-analysis across various healthcare professions, Cavanagh et al. (2020) identified groups exposed to acute suffering and death, such as emergency care, intensive care, oncology, and trauma care nurses, as being the most affected. These epidemiological findings point to the fact that compassion fatigue is not an isolated or personal phenomenon, but rather a predictable and structure-based reaction to the emotional stress that is an intrinsic part of working in healthcare and which has significant consequences for patient safety, workforce sustainability and healthcare quality.

Nevertheless, this evidence base is inconsistent and the term compassion fatigue is used interchangeably with burnout, secondary traumatic stress and vicarious traumatisation in the academic and clinical literature, which have distinct conceptual differences (Sinclair et al., 2017). Such ambiguity is a barrier to the creation of valid measurement instruments, makes it difficult to compare research findings and may mislead and misrepresent organisational interventions. If your concepts are unclear, Sorenson et al., (2016) said that healthcare organisations run the risk of trying to implement a one-size-fits-all stress-reduction program, which doesn't work for the uniquely relational and empathic processes that underlie the development of compassion fatigue. Peters (2018) also found terminological inconsistencies as an impediment to the accumulation of knowledge in this field. This clarity can be achieved through a rigorous concept analysis using Walker and Avant's (2011) method which offers a systematic approach to outlining the attributes that distinguish the concept of compassion fatigue from related concepts, to explore the antecedents and consequences of the concept, and to develop a standardised conceptual foundation for nursing education, research, and health policy.

Aims and Purpose of the Analysis

The primary aim is to clarify the meaning of compassion fatigue as used in nursing and broader healthcare contexts, to differentiate it from related constructs including burnout, secondary traumatic stress, and vicarious traumatisation, and to establish a standardised conceptual definition applicable across clinical, educational, and policy domains. The specific objectives are to identify all documented uses of the concept; to delineate the defining attributes that must be present for the concept to be correctly identified; to illustrate the

concept's boundaries through model, borderline, related, and contrary cases; to identify antecedents and consequences; and to define empirical referents enabling the concept to be measured and studied. These objectives carry direct practical implications: they enable nurse educators to teach compassion fatigue as a conceptually distinct occupational phenomenon; they support researchers in selecting and developing valid measurement tools; and they provide healthcare organisations with a precise foundation for designing targeted prevention and intervention programmes rather than generic occupational wellness initiatives.

Method

Walker and Avant's (2011) eight-step method was selected for this concept analysis on the basis of its systematic structure, its accessibility for application across nursing and health sciences research, and its established utility for clarifying concepts that are widely used but inconsistently defined. The method is particularly well suited to compassion fatigue because the concept occupies an intersection of clinical, psychological, and organisational literatures that each employ it with subtly different emphases. The eight sequential steps applied were: selection of the concept; determination of the aims or purposes of analysis; identification of all uses of the concept; determination of defining attributes; construction of a model case; construction of borderline, related, and contrary cases; identification of antecedents and consequences; and definition of empirical referents. A systematic literature search was conducted in PubMed/MEDLINE, CINAHL, PsycINFO, and Scopus using search terms including compassion fatigue, secondary traumatic stress, vicarious traumatisation, burnout, professional quality of life, nurse well-being, and concept analysis. English-language peer-reviewed publications from 1992 to 2025 were reviewed. Source disciplines included nursing, medicine, psychology, social work, emergency services, and organisational health. Reference lists were hand-searched for additional relevant sources, and synthesis was conducted inductively through iterative thematic review.

Uses of the Concept

Compassion Fatigue is used in various disciplines and professions. It is important to fully appreciate what it can be used for to recognise what is essential and what is elaboration of the definition. Compassion Fatigue is the emotional and physical fatigue that can occur from the ongoing relational work of caring for individuals who are physically in pain, emotionally distress or at the end of life in nursing and clinical health care settings. It was considered a syndrome that results from exposure to seriously ill patients, repeated resuscitation and frequent patient deaths, and leads to a gradual loss of the nurse's ability to empathize and interact in a therapeutic manner in emergency nursing situations (Hunsaker et al., 2015). In the context of intensive care nursing, Jia et al. (2025) have established a direct correlation between compassion fatigue and missed care, the systematic neglect of nursing care, thereby showing that compassion fatigue is not just an emotional phenomenon but a clinical reality that impacts the ability to provide care.

Compassion Fatigue in Psychology & Counseling is used to describe the phenomenon of therapists, social workers, or helping professionals who come into contact with traumatic situations of others in their work. The concept was originally developed in this context by Figley (1995), who focused on "empathic transmission" whereby helpers take on some of the material of the traumatic experience of their clients. Chapman (2021) explored the moderating effect of self-oriented empathy and mindfulness in the development of compassion fatigue in counsellors and found that self-oriented empathy was found to be more likely to be associated with a greater vulnerability. It is used in emergency services, military and disaster response situations to refer to psychological responses to repeated

exposure to mass casualties and sudden traumatic death. Cocker and Joss (2016) found that certain emotional numbing, intrusive symptoms, and professional disengagement occurred consistently with all healthcare, emergency, and community service workers. In all settings, the concept contrasts with burnout, a phenomenon of person-environment fit where role demands and workload are the most important mechanisms, as the specifically relational and empathic mechanism (Spännargård et al., 2022).

The Professional Quality of Life Framework

In order to study both positive and negative outcomes of helping work, Stamm (2010) theorized and developed the Professional Quality of Life (ProQOL) model and validated it as a measurement tool. The model suggests three related components: compassion satisfaction (which is the feeling of effectiveness of helping that can serve as a buffer against compassion fatigue); burnout (which is primarily related to stressors in the organisation and in the role itself); and secondary traumatic stress (which is related to the vicarious exposure to patients traumatic experiences). The buffering effect of CS was found to be significant in a correlative meta-analysis conducted by Zhang et al. (2018) that showed a significant negative relationship between CS and both burnout and secondary traumatic stress. Compassion fatigue is the result of a buildup of burnout and secondary traumatic stress that exceeds compassion satisfaction leading to a reduction in the ability to do work and a reduction in professional satisfaction (Stamm, 2010). Indeed, the difference between these components has clinical implications: interventions to reduce burnout that focus on workload and role clarity will not necessarily be effective for addressing the vicarious traumatic residue that lies at the core of compassion fatigue, and vice versa (Spännargård et al., 2022).

There is a time-based explanation in the five stages of the progression of compassion fatigue model by Figley and Baranowsky (Figley, 1995; Zhang et al., 2023). The first phase (zealot or compassion experience) involves a high level of compassion satisfaction and enthusiasm, and thus sets the stage for the high empathic investment which paradoxically leads to depletion. The second phase is the irritability or “compassion decrement”, when enthusiasm wanes, avoidance behaviours start to occur and disillusionment sets in as demands outweigh coping resources. During the third phase - withdrawal or compassion discomfort, there is increased detachment, persistent exhaustion and maladaptive coping behaviours become a potential risk (Sinclair et al., 2017; Cocker & Joss, 2016). During the fourth phase, the zombie or compassion distress phase, emotional numbing, cynicism, interpersonal conflict and almost complete loss of empathic capacity is evident (Hunsaker et al., 2015). The fifth phase is a bifurcation: either the provider suffers from a severe impairment and is forced to stop working in the profession, or the provider recognizes the need for help, seeks help, and deliberately works towards recovery of sustainable professional compassion (Spännargård et al., 2022; Sorenson et al., 2016). In a constructivist grounded theory study, Zhang et al. (2023) found that clinical nurses could recover if they took a proactive approach and did not just endure.

Defining Attributes

Defining attributes are the cluster of characteristics that most consistently recur across the literature and whose collective presence is necessary for the concept to be correctly identified (Walker & Avant, 2011). Four defining attributes of compassion fatigue were identified.

Prolonged Empathic Exposure to Others' Suffering

The underlying dimension is an ongoing, interpersonal interaction with people in pain, trauma, suffering or dying in a helping relationship that requires and is characterized by empathic responsiveness as both a professional duty and personal action. This is one thing

that sets compassion fatigue apart from burnout that can occur in other occupations with no exposure to human suffering. Empathic engagement was found to be the required mechanism for the development of the compassion fatigue (Figley 1995), and empathic transmission was found to be the process by which the helper gets bits of the sufferer's traumatic experience. Cavanagh et al.'s (2020) systematic review supported the findings that specialties with high prevalence of exposure to acute suffering and death, such as intensive care, emergency, oncology, and palliative care, had the highest prevalence of compassion fatigue, and Cocker and Joss' (2016) study reported similar trends across emergency workers and community service providers.

Emotional Exhaustion and Empathic Numbing

The second is the progressive depletion of emotional/empathic resources, which is measurable and shows a decrease in the ability to experience, express and act on behalf of empathy for the individual to whom one is providing care. This includes emotionally being drained, commonly referred to as emotional exhaustion, and the concept of empathic numbing, which involves a protective response of dampening emotional responses in order to avoid more emotional depletion (Garnett et al., 2023). Specifically in the field of nursing, Peters (2018) conducted a concept analysis of the concept of compassion fatigue and determined that loss of empathy and compassion is the one most clinically significant defining attribute as it is the diminished empathic capacity (not physical tiredness alone) that causes the uniquely relational harm of compassion fatigue and directly impairs the therapeutic nurse-patient relationship.

Secondary Traumatic Stress Symptomatology

The third distinguishing characteristic is psychological symptoms that are typical of secondary traumatic stress resulting from vicarious exposure to patients' traumatic experiences. These symptoms are similar to those found in post-traumatic stress disorder postures – intrusive re-experiencing (nightmares, flashbacks and persistent intrusive thoughts about patients); avoidance of trauma-related stimuli (dreading certain shifts or clinical scenarios); and hyperarousal (insomnia, irritability, hypervigilance), but are activated by the cumulative residue of empathic exposure rather than by primary trauma exposure (Von Rueden et al., 2019; Figley, 2002). The secondary traumatic stress subscale of the ProQOL was the most significant predictor of measures of overall compassion fatigue severity in a meta-analysis of Xie et al. (2021), demonstrating the core element of this attribute within the identity of the construct.

Functional and Professional Decline

Measurable impairment in professional functioning is the fourth defining quality, and includes decreased quality of clinical decision making, increased frequency of errors, decreased therapeutic involvement, decreased professional relationships, and decreased sense of professional identity. Jia et al. (2025) presented direct empirical evidence that compassion fatigue in the ICU nurses is associated with missed care – nursing actions that are partially or completely omitted during the shift, indicating that functional impairment has direct consequences for nursing practices. Von Rueden et al. (2019) reported meaningful relationships between secondary traumatic stress experienced by trauma nurses and self-reported concentration problems, decision-making problems and problems with following clinical protocols. The WestJEM Team (2023) measured functional decline across emergency department workers, and found that compassion fatigue was a significant predictor of increased absenteeism, thinking about leaving the profession and self-reported decreases in the quality of care.

Model, Borderline, Related, and Contrary Cases

Model Case

Model case, show all the attributes in one situation (Walker & Avant, 2011). This 34-year-old Intensive Care Unit (ICU) nurse has spent the past three years working in a trauma Intensive Care Unit (ICU), where she has regularly cared for patients with life-threatening injuries and witnessed many deaths each month. For the past six months she has been having nightmares about the death of individual patients, intrusive thoughts during the day about the inability to successfully treat patients and dread the days before her workday. She says that she doesn't feel concerned for patients any longer, that she doesn't feel anything anymore, that she is becoming more mechanical and very task oriented. They are becoming more irritable, unwilling to communicate with team members, and making more notes mistakes than usual. She regularly uses alcohol to cope with intrusive thoughts and trouble sleeping on days off and has done research on quitting clinical nursing. This case worked to illustrate each of the four characteristics: extended empathic exposure (long term care in the ICU due to trauma); empathic numbness (how she developed an attitude of 'no emotion' and became mechanical); intrusive thoughts, nightmares, and shift dread (how her experiences in the ICU led to secondary traumatic stress); and functional and professional changes (how the experience of being around so much trauma resulted in documentation errors, emotional distancing from others and contemplation of leaving the profession).

Borderline Case

It can include some features and not others, which clarifies some of the necessary conditions of the concept (Walker & Avant, 2011). An accident and emergency nurse has had what she describes as an extremely busy fortnight with two of her patients dying despite them being put through "aggressive resuscitation. She also has several episodes of crying outside of work, complaints of being sad and tired all the time and says that she doesn't feel like she's getting a good night's sleep at home. At the same time, she still finds meaning in her encounters with the few patients who are still alive, hopes for more from her team and has had no intrusive thoughts about patients, avoidance of clinical work, or decrease in empathic responsiveness. She shows signs of acute grief and emotional stress, which are important components of the initial stages of the compassion fatigue continuum, but does not show signs of the total development of the compassion fatigue concept (symptoms of secondary traumatic stress, empathic numbing, and functional deterioration). This marks the threshold between a normal psychological emotional reaction to patient loss and the persistence and dysfunctioning that make up compassion fatigue.

Related Case

A related case is one that shares surface features but has a different core mechanism and essential attributes (Walker & Avant, 2011). A psychiatric nurse working in a community mental health clinic is very frustrated, ineffectual and demoralised. Her concerns have to do mainly with a lack of staffing, high workload, lack of support, and ineffective efforts to get services to improve with management. She reports being emotionally depleted, but does not report any intrusive thoughts about clients' traumatic experiences, avoidance due to vicarious traumatic absorption or significant decrease in empathy. This is burnout and is a result of person-environment fit at the organisation and role level and not the result of the empathic transfer of traumatic experience. The difference is clinically significant: while interventions focusing on workload and role clarity may be adequate in burnout, they are not enough in the case of compassion fatigue, which also involves a vicarious traumatic residue (Spännargård et al., 2022; Stamm, 2010).

Contrary Case

A contrary case shows the opposite to the attributes that define the case (Walker & Avant, 2011). A palliative care nurse whose patients are nearing the end of their life has been doing this for seven years, and tells us that it's very fulfilling. She knows she is in tune with patients and families, knows that she gets professional satisfaction from her work, knows that she does not have any intrusive symptoms or avoidances, and has good and maintainable work and life boundaries. She believes that having regular reflective practice with colleagues and being supported by colleagues and acknowledged by her organisation has helped her to sustain her well-being. This case is an example of compassion satisfaction, the other extreme of the ProQOL construct (Stamm, 2010). It shows that one can sustain a long-term empathic response to suffering and death without compassion fatigue, that with sufficient organisational support, team cohesion and sustainable empathic practice, one can provide long-term, quality care without psychological deterioration - and that the design and support systems in healthcare systems are crucial to such compassionate practice.

Antecedents and Consequences

Antecedents

Antecedents are the conditions which need to be in place for the concept to emerge (Walker & Avant, 2011). The initial antecedent is being highly empathic oriented and maintaining empathic engagement. This same empathic sensitivity that enables nurses to be good caregivers, also provides the interpersonal pathway for vicariously transmission of traumatic material (Figley, 1995; Chapman, 2021). This implies that certain traits, namely those that explain empathy and emotional involvement in patient outcomes, are risk factors and that providers with such traits are at higher risk for empathy erosion, implying that the qualities that make for compassionate practice are the qualities that make for erosion in practice (Garnett et al., 2023). The second antecedent is that patient trauma, suffering and death are experienced and reexperienced. Specialty area and frequency of exposure to traumatic events were among the best predictors of the prevalence of compassion fatigue in a meta-analysis by Xie et al. (2021); a dose-response relationship between the number of traumatic events exposed to and the severity of secondary traumatic stress was documented by Von Rueden et al. (2019). The third antecedent is lack of organisational support, such as understaffing, not having structured psychological debriefing, not having peer support mechanisms, stigmatising cultures and not giving the individual enough down time between intense clinical experiences. The factors that were identified by Cavanagh et al. (2020) as being modifiable antecedents included organisational factors, workplaces with structured emotional support had consistently low prevalence of CF. The fourth antecedent is a lack of personal coping resources such as poor work-life boundary maintenance, lack of self-care, lack of social support outside of the workplace, unaddressed personal trauma, and lack of emotional regulation skills (Peters, 2018; Xie et al., 2021).

Consequences

Consequences are consequences that happen in the wake of the concept's manifestation (Walker & Avant, 2011) (individual, patient, team and organisational levels). Compassion Fatigue manifests progressively on an individual level with mental and physical health issues such as increasing levels of anxiety and depression, insomnia, substance abuse and somatic complaints. A loss of passion and purpose for nursing and a loss of commitment to nursing were reported as some of the individual consequences by Sorenson et al. (2016) and included a professional identity crisis. Consequences, at the level of patient care, are not only empirically established, but ethically pressing. Jia et al. (2025) showed that there was a direct

link between compassion fatigue of ICU nurses and missed care and the consequences on patient safety. A systematic review by Cavanagh et al (2020) has found that functional impairment is associated with increased medication errors, patient falls, HAI and decreased patient satisfaction, supporting the notion that functional impairment is related to measurable clinical harm. Loss of the therapeutic relationship with patients by having a numb and detached attitude by the nurse has a serious implication, because person-centred care relationship is always related to good outcomes of patients in clinical care (Sinclair et al., 2017). Organisational level: Compassion fatigue leads to high staff turnover, more absenteeism and negative work culture dynamics, due to cynicism and workplace withdrawal by affected providers. The WestJEM Team (2023) estimated the magnitude of these organisational impacts within EDs and Zhang et al. (2023) established that the main drivers of leaving bedside nursing is compassion fatigue, with significant downstream consequences for recruitment, training and continuity of care.

Empirical Referents

Empirical referents are categories or phenomena that can be measured and represent the concept in the real world (Walker & Avant, 2011). There were three categories identified. The first, and most highly validated scale, is the Professional Quality of Life Scale, Version 5 (ProQOL-5) by Stamm (2010). The ProQOL-5 is a tool that has three sub scales, validated to measure compassion satisfaction, burnout and secondary traumatic stress and classifies compassion fatigue by a profile of high burnout and secondary traumatic stress scores along with low compassion satisfaction scores. It has been translated and adapted in other languages and culture and with other healthcare professional groups and is the most commonly used measurement tool in the literature pertaining to compassion fatigue (Xie et al., 2021). The Secondary Traumatic Stress Scale (STSS) is an additional measure of secondary traumatic stress symptomatology such as intrusive re-experiencing, avoidance and hyperarousal which is the third defining attribute that sets compassion fatigue apart from generic burnout (Von Rueden et al., 2019).

The second type are clinical and behavioural signs that can be seen or heard – withdrawal from patients and colleagues, absence from work, more often and/or longer, nightmares and sleep disturbance, persistent irritability, quality of documentation declines, and cynicism or desire to leave the profession is expressed. Jia et al. (2025) showed that missed nursing care, a directly auditable process measure, is a valid clinical measure of the severity of compassion fatigue in intensive care (ICU) settings. The third category is organisational audit measures such as staff turnover, attendance, results from staff well-being questionnaires using validated compassion fatigue measures, and trend analysis of incidents relating to attentional or empathic failures and causing clinical error or patient complaints. These organisational indicators were also found to be associated with measurable increases at the department level with the prevalence of compassion fatigue (WestJEM Team, 2023) and so have been suggested as population level monitoring referents.

Implications for Nursing Practice, Education, and Organisation

Organisational Responsibilities

An analysis of antecedents and consequences supports the view that compassion fatigue is not just an individual issue but an occupational and systems-level issue and necessitates a substantive organisational commitment. Healthcare organisations have a primary responsibility to recognise compassion fatigue as a risk of the occupation, establish care cultures where emotional distress can be shared without stigma and take steps to provide cultural and structural protection against its precursors. Structured debriefing programmes

after traumatic clinical events have been highlighted as one of the best evidence-based preventive interventions (Cavanagh et al., 2020), and offer a framework for providers to have a sanctioned space to process traumatic residue that may be experienced through secondary means before reaching pathological levels. Safe nurse to patient staffing is a key structural intervention, because the intensity of workload is a direct moderator of the relationship between empathic exposure and psychological outcome and individual strategies are not enough to prevent increasing compassion fatigue exposure under chronic nurse to patient understaffing. Confidential EAPs (employee assistance programmes) and required psychoeducation for clinical managers to recognize early signs of compassion fatigue symptomatology provide enhanced institutional protection beyond crisis response to proactive surveillance. Evidence-based supports for making these programmatic investments came from Zhang et al.'s (2023) findings that resilience training and mindfulness based programs could be identified as having measurable effects on increasing compassion satisfaction and decreasing secondary traumatic stress.

Individual and Professional Responsibilities

Organisational intervention is the priority but there is a complementary professional responsibility for self-monitoring, boundary management and help seeking by individual nurses. In addition to a heightened awareness and a sensitivity to the progress of compassion fatigue, which is necessary as a first step to intervene in time, there is a need for a tool to self-monitor periodically for early signs before compassion fatigue is in full swing, causing functional decline (Stamm, 2010). Maintenance of boundaries (cultivation of personal and professional identity, end-of-shift decompression and protection of personal time from intrusion of professional identity) is a basic self-care competency and has been shown to have a protective effect (Peters, 2018). Sinclair et al. (2017) highlighted that peer connection with someone sharing the particular emotional context of work in healthcare is essential to peer support and that no other generic support from outside of the context of healthcare work can replicate this sense of normalisation and shared meaning-making. Accessing formal psychological help via employee assistance programmes, private therapy or clinical supervision must be actively de-stigmatised as part of the professional maturity of the individual and the education system should also prepare nurses for the emotional aspects of professional caring as it does for clinical, technical aspects.

Discussion

This concept analysis results in four defining attributes that when present together, make this an occupational phenomenon that is distinct from burnout, general occupational stress, and compassion satisfaction, and therefore the concept can be identified when these four attributes are present. A number of these themes thrown up in this analysis can be considered more widely. This opposing example in this analysis – the palliative care nurse who remains empathically engaged over many years of exposure to suffering and death – shows that it is not necessary that compassion fatigue be a consequence of empathic caring, but rather it is a consequence of empathic caring when it is not accompanied by the appropriate protective conditions. This changes the focus of intervention: from limiting empathic engagement of providers, which would inevitably compromise the quality of care, to establishing organisational, relational and personal settings that facilitate ongoing empathic engagement but do not exhaust providers psychologically. The implications of this change are profound in terms of the thinking and investments to support staff wellbeing in healthcare organisations, from problem solving deficit to systemic capability development.

Xie et al. (2021) documented the measurement heterogeneity in the studies, with many using non-validated tools or with many ProQOL subscales being used as a substitute for the overall compassion fatigue score, which makes comparing across different studies difficult, and can reduce the extent to which results can inform intervention design. Having a conceptual definition as in this analysis and standardisation of measurement would significantly improve the rigour of research. The equity dimension also deserves to be considered: the populations most affected by the lack of organisational supports most protective against CF are those in under-resourced, high acuity and emergency settings and those in low resource countries. Of the metasynthesis of compassion fatigue in nurses by Nolte et al. (2017), the studies suggest that resource-limited environments may be the most dangerous places for compassion fatigue to occur, as they tend to focus on the antecedents. To address the issue of compassion fatigue equitably, it is important to think of this issue as a global health equity concern, not just as an individual occupational health and safety concern, and to invest at the health system-level where need is greatest and resources are smallest.

Conclusions

Compassion fatigue is a significant, research supported, occupational risk factor in nursing and health care, and requires a systematic approach toward identification and intervention. This concept analysis has resulted in a standardised definition, based on four defining attributes such as prolonged empathic exposure, emotional exhaustion and empathic numbing, secondary traumatic stress symptomatology, and functional and professional decline and distinguished it from burnout, secondary traumatic stress and compassion satisfaction as related, but conceptually distinct phenomena. Thus the analysis finds that compassion fatigue is a systemic issue related to the conditions under which empathic professional care is provided and is not merely individual and can be solved by personal resilience. Effective prevention means having the organisational structural supports of adequate staffing, de-briefing infrastructure, access to psychological support, and destigmatised help-seeking cultures as well as individual self-awareness, boundary management, and purposive self-care practices. The emotional aspects of the work of professional caring are a domain of competence in nursing education which must be integrated into the curriculum for preparing nurses for their profession. Ultimately, maintaining the compassionate dimension of health care providers is not a welfare matter but a matter of patient safety - the quality, safety and humanity of patient care hinges directly on the psychological well-being of the providers.

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