

**The Cost of Caring: A Systematic Analysis of Compassion Fatigue Among
Intensive Care Unit Nurses**

Student Name

Department of Advanced Nursing Practice, University of Edinburgh

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Professor Alistair Graham

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Abstract

Compassion fatigue is an increasingly prevalent phenomenon in high acuity healthcare settings, particularly within Intensive Care Units. Unlike burnout, which is often related to workplace environment and administrative burden, compassion fatigue is specifically linked to the emotional residue of exposure to others trauma. This research paper examines the prevalence, predictors, and consequences of compassion fatigue among Intensive Care Unit nurses. Utilising a United Kingdom centric lens, the paper explores how the high pressure environment of the National Health Service, combined with the ethical complexities of end of life care, contributes to emotional exhaustion. Findings suggest that organisational support, clinical supervision, and emotional intelligence are critical factors in mitigating compassion fatigue. The paper concludes with recommendations for institutional interventions to safeguard the mental health of the Intensive Care Unit workforce.

Introduction

The Intensive Care Unit is an environment defined by its intensity, technical complexity, and frequent encounters with mortality. Nurses working in these settings are expected to provide high level clinical interventions while simultaneously offering emotional support to patients and their families during some of the most traumatic moments of their lives. While the ability to empathise is a cornerstone of nursing practice, prolonged exposure to patient suffering can lead to a state of emotional exhaustion known as compassion fatigue. Figley (1995), often cited as the pioneer of this concept, describes compassion fatigue as the cost of caring for those who suffer. In the context of contemporary United Kingdom nursing, where the National Health Service faces chronic understaffing and increasing patient acuity, the risk of compassion fatigue among Intensive Care Unit practitioners has reached a critical threshold.

The phenomenon of compassion fatigue is distinct from burnout, though the two often overlap in clinical literature. Burnout is typically an occupational hazard associated with the workplace environment, such as long hours, lack of resources, and poor management. In contrast, compassion fatigue is a direct result of the empathetic relationship between the clinician and the sufferer. It is a state of tension and preoccupation with the individual or cumulative traumas of patients. For nurses in the Intensive Care Unit, this trauma is often chronic and multifaceted, involving sudden cardiac arrests, complex polytrauma, and the heavy emotional weight of facilitating communication between grieving families and medical teams.

Theoretical Framework: The ProQOL Model

The most widely accepted framework for understanding compassion fatigue is the Professional Quality of Life model developed by Stamm (2010). This model posits that professional quality of life is composed of two main aspects: Compassion Satisfaction (the positive feelings derived from helping others) and Compassion Fatigue. Compassion fatigue is further subdivided into two components: Burnout (exhaustion, frustration, and anger) and Secondary Traumatic Stress. Secondary Traumatic Stress specifically refers to the negative feeling driven by fear and work related trauma. For Intensive Care Unit nurses, Secondary Traumatic Stress often manifests following unsuccessful resuscitation attempts or traumatic deaths, where the nurse absorbs the trauma experienced by the patient or family.

Stamm argues that the balance between satisfaction and fatigue determines the overall well being of the practitioner. When a nurse is able to find meaning and purpose in their work despite the trauma, they experience compassion satisfaction, which acts as a buffer against fatigue. However, when the volume of trauma outweighs the perceived rewards of the job, the nurse enters a state of emotional bankruptcy. In the Intensive Care Unit, this balance is frequently disrupted by systemic pressures. The constant influx of critically ill patients means that nurses rarely have the opportunity to process one traumatic event before the next one occurs. This cumulative effect is what leads to the profound exhaustion seen in modern nursing cohorts.

Prevalence and Predictors in the Intensive Care Unit Setting

Research suggests that Intensive Care Unit nurses are at a significantly higher risk for compassion fatigue compared to nurses in lower acuity wards. A study by Sacco et al. (2015) found that the constant presence of end of life care and the ethical dilemmas associated with withdrawing life sustaining treatment are primary drivers. In the United Kingdom, the post code lottery of resource allocation and the pressure of bed management add a layer of systemic stress that compounds individual emotional labour.

The environmental stressors of the Intensive Care Unit include the constant noise of monitors, the physical demands of patient care, and the high stakes nature of medication administration. These factors contribute to a baseline level of stress that leaves nurses vulnerable to emotional exhaustion. Furthermore, the intimacy of Intensive Care Unit nursing, where a nurse often cares for only one or two patients at a time, creates a deep bond that makes the patient suffering more personal. This professional intimacy is a strength of the nursing role, but it also serves as a gateway for compassion fatigue when outcomes are poor.

Individual predictors also play a role. Nurses with lower levels of clinical experience often report higher Secondary Traumatic Stress, as they may not yet have developed the coping mechanisms necessary to compartmentalise trauma. Conversely, senior nurses may experience higher levels of burnout due to the cumulative effect of years of emotional demands. Furthermore, a lack of personal resilience and poor work life balance are consistently linked to the onset of compassion fatigue symptoms, which include intrusive thoughts, insomnia, and emotional detachment (Al Majid et al., 2018).

Impact on Patient Care and Staff Retention

The consequences of compassion fatigue extend beyond the individual nurse well being; they pose a direct threat to patient safety. When nurses experience compassion fatigue, their ability to provide compassionate, patient centred care is diminished. This often leads to objectification of the patient as a defence mechanism against further emotional pain. Errors in

clinical judgment become more frequent as cognitive fatigue sets in. Moreover, compassion fatigue is a primary driver of nursing attrition. Within the National Health Service, the cost of replacing a specialised Intensive Care Unit nurse is substantial, encompassing both the financial burden of recruitment and the loss of institutional knowledge.

Staff turnover in critical care areas has reached alarming levels in recent years. As more nurses leave the bedside due to emotional exhaustion, the workload for those remaining increases, creating a vicious cycle that further exacerbates the prevalence of the condition. This leads to a degradation of the clinical environment where mentorship is lacking and the safety of the unit is compromised. The emotional health of the nurse is therefore not just a personal issue but a critical component of healthcare infrastructure and patient outcomes.

The Role of Moral Distress

A unique factor in the Intensive Care Unit is the high incidence of moral distress, which is the psychological distress that occurs when one knows the ethically correct action to take but is prevented from doing so by institutional constraints. For example, a nurse may believe that continuing aggressive treatment for a patient with a terminal prognosis is futile and inhumane, yet must carry out medical orders to do so. This dissonance between the nurse professional values and their clinical actions is a potent catalyst for compassion fatigue. Addressing moral distress through ethics debriefings and inclusive multidisciplinary rounds is essential for reducing the emotional burden on nursing staff.

Moral distress is often compounded by poor communication within the medical team. When nurses feel that their clinical observations and ethical concerns are ignored by senior physicians, the sense of powerlessness increases. In the United Kingdom, the hierarchical nature of some medical settings can stifle the voice of the nurse, leading to a sense of professional betrayal. By fostering a culture of mutual respect and shared decision making, healthcare organisations can mitigate the moral injury that leads to compassion fatigue.

Organisational and Individual Interventions

Mitigating compassion fatigue requires a dual approach. Individually, nurses must be encouraged to practice self care and develop emotional intelligence. However, the onus must not rest solely on the individual. Organisational interventions are paramount. The implementation of Schwartz Rounds across National Health Service trusts has shown promise in providing a safe space for staff to share the emotional challenges of their work. Additionally, providing access to clinical psychologists specialised in occupational trauma can offer targeted support for those in high stress areas.

Safe staffing levels are the most effective organisational intervention. When nurses have a manageable patient to nurse ratio, they have the time to process clinical events and provide the quality of care that leads to compassion satisfaction. In the absence of structural support, individual resilience training is often perceived as a plaster on a gaping wound (Maben and Bridges, 2020). Authentic leadership that recognises the emotional labour of nursing is also vital. Leaders who are visible on the unit and who actively seek to improve the working conditions of their staff can significantly reduce the incidence of burnout and fatigue.

Conclusion

Compassion fatigue among Intensive Care Unit nurses is a complex, multifaceted issue that threatens the sustainability of the critical care workforce. While the Intensive Care Unit will always be an environment of high emotional demand, the development of compassion fatigue is not an inevitable outcome of the role. Through a combination of robust organisational support, the fostering of moral resilience, and a systemic commitment to staff well being, it is possible to protect those who dedicate their lives to protecting others. The future of Intensive Care Unit nursing depends on our ability to recognise that the cost of caring must not be the health and career of the caregiver.

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