Nurses’ perceived and actual caregiving roles: identifying factors that can contribute to job satisfaction

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Aims and objectives. To compare nurses’ caring expectations with their caregiving experiences and to identify factors that could potentially be included in a preliminary conceptual model of job satisfaction and compassion fatigue.

Background. Nurses often report emotional reward and satisfaction in their profession from compassionately caring for sick and injured patients. However, being in close proximity to trauma can eventually deplete a nurse’s compassion and empathy for the patients they care for. This loss of compassion is further exacerbated by demanding work environments that involve administrative duties, attending to patients’ psychosocial needs and interacting with patients’ families. To date, the literature has tended to focus on pathology of compassion fatigue, rather than identifying its contributing factors.

Design. A grounded theory approach was used to identify emerging themes in nurses’ accounts of their caregiving roles.

Methods. Open-ended interviews were conducted with nurses (n = 9) who were employed by a maritime district health authority for a minimum of five years. Interviews focused on beliefs of how to provide care, perceived caregiving responsibilities and perceived challenges in the provision of care.

Results. Emerging from the data is a proposed model of job satisfaction. The concepts of monitoring and patient advocacy appeared to be key components in reported satisfaction or alienation. Discrepancies were found between care expectations outlined by management and nurses’ perceptions of care provision. Additionally, type of nursing education was related to nurses’ confidence in applying nursing skills.

Conclusions. These findings have implications for training programmes, hospital management and quality of patient care.

Relevance to clinical practice. It is important to identify factors that could explain resilience to compassion fatigue because compassion fatigue has negative consequences not only for nurses themselves but for the patients in their care.

Key words: caregiving roles, compassion fatigue, nursing

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What does this paper contribute to the wider global clinical community?
• A greater understanding of competing demands faced by formal caregivers in global communities in which cost savings translate to increased roles for and risk of compassion fatigue.
• An identification of factors that could contribute to compassion fatigue resilience provides valuable information which may be used for preventive purposes and consequent reductions in workplace burnout.
• Identifying management-nurse discrepancies in work expectations may promote more fluid communication between administrators and caregivers and ultimately reduce stress and workplace burnout.
**Introduction**

The overall physical and emotional demands of the nursing profession put nurses at risk of professional compassion fatigue. Formal caregivers’ needs for care are often neglected as caregiving energy is directed towards patients. Furthermore, in the healthcare setting, patients’ expectations of quality care appear to be increasing, while concurrently, nurses are experiencing greater difficulty in defining their professional roles (Fourie et al. 2005). Although attending to the many needs of the patient is of top priority to nursing staff, greater administrative duties have been imposed upon nurses, limiting available time to care for and interact with patients (Fourie et al. 2005). Nurses are regularly exposed to human suffering, which increases their needs for self-care and emotional decompression. These needs are frequently unmet as increased professional and family responsibilities are juggled. Although there is potential for financial and emotional reward and satisfaction in compassionately caring for sick, wounded and traumatised individuals (Coetzee & Klopper 2010), consequences of caregiving include high levels of emotional exhaustion, de-personalisation and workplace stress (Grafton et al. 2010).

Compassion fatigue remains poorly described, and little research appears to be focused on specific contributors to this phenomenon. The current research uses methodology informed by grounded theory (Corbin & Strauss 2008). It is both timely and relevant given the increases in depression and burnout among healthcare professionals.

**Background**

The term ‘compassion fatigue’ was first used to describe a growing indifference to and reduced empathy towards social problems and crises (Austin et al. 2009). It is a relatively recent term describing a specific new phenomenon in the realm of health care (Joinson 1992). Upon observing nurses working in an emergency department, Joinson (1992) described nurses who were ‘burned out and burned up’ by caring for others (p. 116). Caring, empathy and emotional investment were identified as putting professionals at risk (Figley 1995). Thus, compassion fatigue reflects an overwhelming stress resulting from helping or wanting to help a traumatised or suffering person (McGibbon et al. 2010), consuming the individual’s energy and permeating their lives (Austin et al. 2009). In other words, nurses feel unable to ‘let go’ of work and have difficulty maintaining a professional–personal life balance (Austin et al. 2009).

Prior to the use of the term *compassion fatigue*, nurses’ stress was conceptualised as secondary traumatic stress (STS; Sabo 2006). Figley (1995) indicated that there was a ‘cost of caring’ for others in emotional pain. Rather than experiencing post-traumatic stress disorder (PTSD), healthcare providers suffer from secondary traumatic stress disorder (STSD) – nurses are indirectly exposed to those traumatic stressors experienced by patients and thus display symptoms similar to those of the victim (Beck 2011). Compassion fatigue is synonymous with secondary traumatic stress (Figley 1995). Compassion fatigue/STS in those who treat traumatised victims may experience the following: anxiety and depression, dreams or recollections of a traumatised person, avoidance of reminders of a traumatic event described by a traumatised person (i.e. detachment from others, difficulty sleeping, difficulty concentrating and an exaggerated startle response (McGibbon et al. 2010, Figley 1995).

The concept of compassion fatigue seems to imply an earlier state with some compassion that has been lost (Austin et al. 2009). Therefore, central to the understanding of compassion fatigue is developing an understanding of the original compassion and empathy, as well as their diminish-ment. Compassion is a pro-social emotion that includes recognising the suffering of another in combination with a desire or motivation to alleviate that suffering (Sabo 2006). Empathy is a key component of the helping relationship between nurse and patient (Sabo 2006). Empathy requires that the nurse perceive the world as the patient does in a nonjudgmental way and tries to understand the patient’s feelings. Caring, compassion and empathy can exhort a cost from caregiving providers, reducing their capacity or interest in carrying the burden of others. Sabo (2006) referred to empathy as a ‘double-edged sword’ for the nurse: on one hand, empathy facilitates caring work; on the other hand, the act of caring leaves the nurse vulnerable to suffering him or herself (p. 138).

It is well-established, both empirically and anecdotally, that nursing is a stressful profession. Central to the work of most nurses is engagement in bodily or bedside caring (McGibbon et al. 2010). This includes the physical aspects of care, such as feeding, changing dressings and taking blood samples. Bodily care that involves inflicting pain or making the patient uncomfortable can be stressful for nurses. Embedded in the work environment of nurses is the notion of always thinking ahead – they are attending, monitoring, organising and overseeing (McGibbon et al. 2010). In other words, they are always doing. It cannot be known when a medical or nonmedical emergency will occur or when a patient will be in need. Nurses must remain alert, not only to ensure the well-being of their patients, but to inform doctors of patients’ changing conditions. Further
adding to the list of demanding circumstances are heavy and intense workloads, staff shortages and a lack of resources to do work effectively (Coetzee & Klopper 2010). The list of demands leaves little doubt that nurses are subjected to many sources of stress. The adverse effects of the workplace environment can have an impact on nurses’ emotional well-being and their ability to provide compassionate care (Coetzee & Klopper 2010). In addition to workplace stress experienced by nurses already in the workforce, it is suggested that graduate nurses entering the workplace for the first time often encounter a ‘reality shock’ as they adapt to the stressful reality of the work environment (Grafton et al. 2010).

The growing burden of administrative activities has been seen as detracting from the caregiving roles of the nurse (Fourie et al. 2005). Jackson and Stevenson (2000) found that time spent providing care to patients was often diluted by tasks such as admitting patients, dispensing drugs, office paperwork, discharge planning and meetings. Although it cannot be denied that documentation is important, the demand of completing paperwork is time-consuming and energy-draining, leaving insufficient time for patient care (Fourie et al. 2005). Additionally, it appears that nurses often feel that their practice is judged by what they document and not necessarily by the actual quality of care provided (Fourie et al. 2005).

Moreover, in a typical hospital setting, nurses are the only persons present whose time allotted for caring is long enough to develop a therapeutic relationship with patients (Fourie et al. 2005). Their exposure in shifts that span the 24 hours lend themselves to form connections with patients, which are markedly different than those of any other clinician (McGibbon et al. 2010). Furthermore, their spatial proximity means that they are physically close to patients in a way that is also unique. While physical care may be thought of as the key component of the nursing profession, there is also a belief that nurses should attend to the emotional and psychological needs of patients and their families. Being surrounded by and empathically engaged in the distress of others can be emotionally taxing. Nurse participants in a study by Austin et al. (2009) described distancing themselves from patients and families by directing their focus to providing ‘just the basics’ (p. 204). To withdraw from patients and avoid further exposure to suffering, they began to focus on more technical aspects of care and limited genuine engagement with patients and families. Although not pausing to engage with people in a meaningful way is often employed as a coping mechanism, it can lead to feelings of depersonalisation in nurses (Austin et al. 2009). Consequently, patients sense the nurse’s stress and respond in a similar fashion; this further diminishes the likelihood of an engaging interaction between patient and nurse. Without nurse–patient engagement, the nature of nursing work changes from meaningful interaction to mere activity. The job title or label of ‘nurse’ is often a significant component of a nurse’s self-identity (Burton & Stichler 2010). Diminished sense of competency paired with lack of job satisfaction and meaning can create an existential crisis for the nurse who derives sense of self from his or her job. In addition, new and more complex equipment has begun to occupy nurses’ time and may result in less direct contact with patients and increased feelings of depersonalisation (Liaw 2011). Such feelings can create uneasiness and stress among nurses by reducing the possibility of displaying and realising ideals of good nursing care.

Emotional distress has been identified as a form of stress in nurses’ everyday work (McGibbon et al. 2010). Emotional distress can span many different kinds of situations as nurses experience their own emotions while witnessing and attending to the emotions of patients and families. Nurses have noted the difficulty of being close with families and regularly being around death at work (Running et al. 2008). They often feel emotional containment is necessary. Nurses must hide their emotions from patients and colleagues, and they are given little time or opportunity to grieve (Running et al. 2008). The compassionate qualities that attract nurses to specialty areas are also a source of vulnerability to the negative impact of work-related stress (Grafton et al. 2010). Stress encountered as a consequence of empathic engagement can deplete the spirit of the nurse and result in diminished personal resources and resilience; this may manifest as compassion fatigue (Grafton et al. 2010). Many areas are perceived as both personally and professionally demanding (i.e. oncology, palliative care) due to additional stressors that are unique to its specialty. The additional stressors that are unique to these certain specialities include, but are not limited to, grief, loss, bereavement, treatment regimens and managing professional boundaries in regard to relationships with patients and their families (Zander et al. 2010).

Patient health outcomes have become a driving force within healthcare delivery (Sabo 2006). Little emphasis has been placed on the potential health consequences for the nurses providing care. Compassion fatigue has emerged as a consequence of caring for patients who are in pain, suffering or traumatised (Sabo 2006). Nurses often perceive their therapeutic role as the most important component of caregiving, but the many demands placed on a nurse are overwhelming and constrain the therapeutic relationship.

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Stress, and particularly prolonged stress, can be detrimental to physical and mental health (Grafton et al. 2010). Researchers assert that it is not so much the actual stress but rather the individual’s perception of and response to stress that affects physical and psychological well-being, implying that developing toughness or resilience would reduce the effects of compassion fatigue.

Resilience is a concept that refers to an ability to adapt to and reframe stressful situations as positive learning experiences. Little research exists identifying resilience-promoting factors for compassion fatigue. There also has been little focus on the relation between years of experience and onset, whether novice or experienced nurses are more susceptible, or whether certain speciality areas (i.e. oncology and palliative care) are more or less stressful.

In light of the literature, the present study seeks to elaborate on the following research questions: (1) Do discrepancies between perceived and actual caregiving roles exist, and if so, do they make nurses vulnerable to compassion fatigue? and (2) Do discrepancies between ideal and actual nursing environments contribute to compassion fatigue? The objectives of the research are to compare the types of care nurses expect to provide, to identify whether and when a disconnect between expectations occurs and to provide insight on factors that may contribute to compassion fatigue.

Methods
Design
Ethics approval was obtained from the district health authority in which the study was conducted. A convenience sample of nine registered nurses (eight women and one man) took part in this study. All nurses were employed by the same district health authority in a small Canadian maritime community. Participants’ years of experience as a registered nurse ranged from 5–27 years, and types of experience included emergency, palliative care, mental health, acute care and long-term care.

Data collection
Data were gathered through in-depth, semistructured interviews. A set of open-ended questions created by the researcher were used as an interview guide. The questions centred on perceptions of caregiving roles, work environments, sources of stress and job satisfaction. Further sources of data included recordings, transcripts, interview notes and reflective memos spanning the length of the study. The reflective memos document the researcher’s thoughts over the course of the study and thus serve as a source of reliability and control for potential underlying biases.

Interviews were conducted at convenient locations chosen by the participants and lasted approximately one hour. During the interviews, the researcher explored the nurses’ experience of working in situations that brought about stressful symptoms. The objective of the semistructured format was to elicit the participant’s story wherein questions focused on potential factors contributing to workplace stress and the phenomenon of compassion fatigue. They touched on topics such as perceived caregiving roles, nursing environments and aspects of the job that demand the most energy.

All interviews were audio-taped and transcribed. Participants were given pseudonyms, and identifying information was removed during transcription.

Analysis
This study used the grounded theory method (Glaser & Strauss 1967) to explore the phenomenon of compassion fatigue as experienced by nurses. Grounded theory is an emergent methodology that has the goal of generating concepts that explain people’s actions, regardless of the time and place (Starks & Trinidad 2007). The goal of the current study was to allow for a model of compassion fatigue to emerge from the data gathered by interviewing nurses.

Through the process of constant comparison, coding of the data followed through three stages: open coding, axial coding and selective coding (Starks & Trinidad 2007, Corbin & Strauss 2008). The researcher recorded memos on index cards, which were compared with interview data.

Results
Various caregiving roles
The nurses in this study identified that they had a ‘plethora’ of roles placing competing demands on them. Caregiving roles identified by the nurses in this study fell into the following categories: patient and family advocacy, monitoring and administrative duties.

Patient advocacy
Nurses unanimously identified patient advocacy as their primary role: nurses advocate for and protect the health,
well-being, safety and rights of the patients in their care, who often are in a position of vulnerability (i.e. due to illness, mental status or limited knowledge of hospital settings). Participants emphasised that physical care – which includes attending to wounds, administering medication and assisting in personal hygiene – is only one component of their job and that their roles encompass a vast scope. ‘You are responsible for their bio-psycho-social, sexual, and spiritual needs’ (Tom). The nurses acknowledged that attending to psychological and social needs is an important aspect of care. They believed it would be difficult, if not impossible, not to attend to psychosocial needs while on the job.

You’re interacting with patients from the moment you come on shift and you take measures to ensure their psychological health... Even if you don’t realize it, you have to be able to assess their mental status so you can provide care in a way that is most helpful to the patient. (Amanda)

Information and education must be delivered in a way patients can understand, meaning nurses must be aware of what the patient can or cannot comprehend. For example, a patient with dementia perceives things differently than does a patient without dementia who may have a hearing problem. This sample of nurses made a clear distinction that each patient has to be treated in a way that is specific to their ‘plethora’ of needs.

Patient advocacy had both positive and negative outcomes. By being an advocate on behalf of the patient, nurses felt they were helping individuals who cannot help themselves. This is inherently rewarding by reinforcing that the nurses are making a difference. On the other hand, nurses felt they faced criticism – from doctors, family, colleagues and management – in the process of satisfying the needs of the patient. The nurses in this study stated that they were focused on providing care that was in their patients’ best interests, but there can be differences of opinion on what ‘the best’ is. Nurses in the current study expressed feeling negative consequences from patients’ family members and from upper management.

Moreover, nurses stated that they felt the need to act as a family advocate as well (provided this role did not conflict with patient care). This interaction and connection with patients’ families yields what one nurse called ‘collateral clients.’ ‘We’re not just treating the patient, we’re treating the family. You have to treat the whole person’ (Jane). Dealing with family often presents an added challenge to the nurse. All participants in this particular study mentioned that families are typically more difficult to deal with than patients.

Monitoring
Monitoring refers to continuously checking up on a patient’s status. Nurses work on the front line of hospital settings, granting them a unique positioning to patients. Nurses are in contact with patients more than any other health professional. Being involved in patient care and assessing patients over time grants nurses the ability to recognise subtle changes in a patient’s condition. Monitoring includes monitoring doctors’ orders (i.e. being aware of whether something is safe or not), observing how patients are doing (i.e. psychosocial well-being) and checking vitals (i.e. respiratory rate, blood pressure).

Monitoring is a constant, ongoing process that requires constant environmental and patient assessment. Additionally, in this study, the theme of monitoring stretched to include nurses’ self-monitoring, which involved conducting periodic ‘self-checks’ to identify their own coping abilities across settings. Self-monitoring was especially prevalent for nurses with experience in mental health and palliative care, perhaps due to the unique emotional exhaustion of these specialty areas. The well-being of the nurse goes largely ignored. For this reason, engaging in a self-check seems necessary because the nurses believe that one must be at their best to take care of others: Just because you have RN behind your name doesn’t mean you are a good person or that you are less vulnerable, you’re as vulnerable as anyone else, you have to be constantly assessing yourself. (Alice)

Administrative duties
It has been identified in the literature that there is a growing demand for administrative duties by nurses; nurses from the present sample agreed: ‘There is lots and lots and lots of paper work. I have to chart everything on everybody’ (Jane). Administrative duties involve documentation and charting information on each patient. Management emphasises thorough, well-organised documentation, which can require a significant amount of mental energy when paired with the many other roles a nurse must fulfil. The demand on mental energy can also be attributed to the amount of responsibility attached to administrative duties: ‘Management emphasizes that to be safe in this world you have to be thorough. If you’re reprimanded you have to be safe with documentation’ (Alice). Older patients often have more complex problems which are an added difficulty in keeping sufficient documentation. Nurses have identified that they would prefer less charting because it is time-consuming and takes away from time that could be spent providing care.
Education and efficacy

In this particular study, the type of training a nurse received – either a two-year nursing school degree or four-year university degree – influenced the amount of confidence he or she had in applying learned skills once in the field. Perhaps surprisingly, nurses who went to nursing school were more confident in their abilities as a novice nurse. Nursing school grads felt they had a more ‘hands-on’ experience and expressed concern over new nurses coming into the field with a university degree (nursing school is no longer an available opportunity), saying they appear nervous and weary of their own decision-making ability. Nurses from both training backgrounds were congruent in caregiving roles they identified and agreed that in school you were taught an ideal and suffered a ‘reality shock’ upon entering the field.

Discrepancies

The basis for this study focused on the belief that discrepancies in perceptions of nurses’ roles could potentially result in one being vulnerable to workplace stress and the negative consequences that follow. The main discrepancies identified in this study revolved around funding and management.

Funding

The nurses in this study felt that funding contributed to and/or created discrepancies in their work environments. This relates to inadequate staff and lack of adequate equipment needed to make diagnoses. In the maritime district health authority where our sample was drawn, the regional hospital is the largest healthcare facility and has the most resources. Often, delays in diagnostic procedures and treatments for patients from communities outside the main region produce a great deal of wait-time for results, exposing nurses to pressure from patients and family members who are anxious and desperate for information.

Management

There is a discrepancy between management’s expectations of care delivery and nurses’ perceptions of how to provide care. Nurses felt management had unrealistic expectations of care output and did not take into consideration the variety of roles they must fulfil to have done their job. One nurse stated:

A skill orientation is emphasized by management, they are more concerned with the quantity of care rather than the quality of care you can deliver, or at least this is how it feels when you’re working, so when you take time to interact with patients – acknowledging the psychological and or social aspects of things – it feels like it’s being frowned upon, it’s like they feel it’s taking away from time where we could be producing more tangible output. (Amanda)

Nurses reported a pervasive feeling of disapproval and criticism from upper management. They perceived management as having unrealistic expectations of care output that assumed all patients are the same and felt that management ignored the need for individually tailored care:

Oh in a perfect work, I could go in and be totally patient care, no paperwork, that sort of thing. It would be all patient-oriented. I understand that there is paperwork and supervisory work involved, but ideally I would like to go in and provide care for my patients and that would be it. They [administration] don’t see the whole picture; they only see bits and pieces. (Jane)

Nurses expressed that they do not receive support from administration, as one participant asked the infamous question, ‘Who’s taking care of the caregiver?’ Nurses perceive management as lacking care for its own employees’ well-being and as more business-oriented than patient-oriented:

Their duty is to keep the patient safe from you [the nurse]. They don’t bother to check if their own nurses are okay psychologically, they don’t realize they’re just as vulnerable as anyone else. We are not given any time to grieve or recollect ourselves when something traumatic happens to a patient or colleague. (Tom)

Furthermore, nurses’ opinions are not given as much value as the opinions of other healthcare professionals:

Nurses are closest to the patient, we see them every day, we do the most, but our opinions aren’t taken with as much emphasis… Not to say we’re always right or know best, but it would be nice to have our opinions mean something. (Alice)

Management undermines the autonomy of its own nurses. In-services are held frequently about procedural issues such as proper hand-washing and documentation.

Nurses do not feel like they have time to attend such meetings and expressed that

‘management should utilise their time more efficiently’. (Amanda)

Conceptual model: job satisfaction model

Emerging from the data is a proposed model of job satisfaction that is based on how nurses respond to exposure to demanding work environments that require empathic engagement with individuals (Fig. 1). The job satisfaction
model begins by acknowledging that nurses have a demanding work environment. Nurses have a variety of caregiving roles (i.e. physical care, psychosocial needs, advocating), and there are discrepancies that place unnecessary burden on the nurse. A demanding work environment is combined with an empathic response because in healthcare settings there is exposure to the experiences of suffering individuals. These two components are intertwined and can be interpreted and evaluated in different ways by individual nurses.

A nurse could perceive having control over his or her environment and see difficulties faced as challenges that he or she is able to overcome. Such accomplishments are rewarding and create energy for one’s job. Examples of reward and energy given by nurses in this particular study included: ‘I love my job’, ‘it’s the most rewarding thing anybody could do’ and ‘I feel good about myself for helping others’. Acknowledgement or awareness of rewards and energy contribute to a feeling of connectedness to one’s job, colleagues and/or patients. For example, ‘I feel connected to each and every patient in some way’ and ‘I can’t imagine doing anything else’. In this scenario, there is no loss of empathy or compassion. Under these circumstances, the end result is apparent job satisfaction – ‘When I go to work I give it my best and work hard; at the end of a shift I take satisfaction out of a sense of a job well-done’ (Amanda).

Although the study also aimed to identify a model of compassion fatigue, we were unable to do so because all nurses in our sample expressed satisfaction with their job. It is possible to hypothesise a corresponding model of compassion fatigue that is opposite to job satisfaction. For example, a nurse could perceive a lack of control (i.e. powerlessness) and feel threatened by difficulties presented by the combination of a demanding work environment and trying to compassionately care for others. The individual could be left feeling defeated and experience negative consequences such as poor mental health, low motivation and missing time from work. Not receiving positive feedback or a sense of reward from work behaviours could result in a sense of disconnectedness (i.e. the individual does not derive any personal meaning from or feels ambivalent towards his or her job). Under these circumstances, any previously existing compassion or empathy would be lost and the phenomenon likely to result is compassion fatigue. However, this is only a hypothesised account of what may occur. It was not possible to derive an actual conceptual model of compassion fatigue from accounts given by nurses in this sample.

**Discussion**

The Job Satisfaction Model that emerged from the data is consistent with aspects of psychological hardiness (Kobasa 1979, Lambert et al. 2003) and conceptualisations of burnout (Maslach et al. 2001, Beck 2011).
Psychological hardiness is the ability to rise to environmental challenges and turn stressful life events into opportunities for personal growth (Lambert et al. 2003). Conceptualisations of psychological hardiness centre on the concepts of commitment, control and challenge. Control is seen as being able to influence life’s events rather than being helpless to them, whereas challenge is the ability to overcome difficulties that life presents and not feeling threatened by them. Consistent with psychological hardiness, perceptions of control and challenge are both aspects of the proposed model. The term connectedness in the Job Satisfaction Model is synonymous with commitment from psychological hardiness. However, the model differs slightly in its positioning of connectedness. Psychological hardiness refers to the interaction of commitment, control and challenge; all three variables are interrelated as opposed to sequential events. The Job Satisfaction Model suggests that upon perceiving control and optimal challenge from a work environment, individuals first derive rewards from their job and feel energetic towards their work. Rewards and energy either create or strengthen connectedness (i.e. commitment) to one’s job.

Burnout and compassion fatigue share several similarities and sometimes they are mistakenly used interchangeably. These shared similarities make it useful to draw on burnout research in the discussion of compassion fatigue. Both burnout and compassion fatigue can occur in environments where there is too much work with unreasonable expectations of completion (i.e. time urgency), role conflict and absence of job resources (i.e. social support; Maslach et al. 2001). Burnout and compassion fatigue have also been related to absenteeism, intention to leave one’s job and job turnover (Maslach et al. 2001).

The Maslach Burnout Inventory (MBI) was created to measure burnout in workers in the human services, such as health care (Maslach et al. 2001). The three key dimensions of the MBI are exhaustion, cynicism and reduced efficacy. It is useful to consider the MBI in the development of a model of compassion fatigue. However, it is important to be mindful that burnout and compassion fatigue are qualitatively different phenomena. Burnout is described as a state of physical, emotional and mental exhaustion, which is a result of long-term involvement in demanding work-related situations (Bush 2009). Compassion fatigue refers to the stress experienced by nurses who empathically engage with patients and their families. When exposed to trauma and loss, sometimes the caregiver begins to integrate the emotions, fears and grief of their patients (i.e. secondary traumatic stress), ultimately increasing their own stress and pain (Bush 2009). It is argued that compassion fatigue breaks away from traditional conceptualisations of burnout in its unique reference to a state of compassion and empathy that is lower than what once existed – the individual’s resources to engage empathically with others have been exhausted or fatigued.

Maslach also created a burnout inventory for teachers, which is a useful point of comparison between burnout and compassion fatigue: both a teacher and a nurse could suffer from burnout (i.e. depletion of resources, lowered motivation), but a teacher could not suffer from compassion fatigue (i.e. no empathic engagement with traumatised individuals).

Ultimately the concept of compassion fatigue differs from burnout by acknowledging the key component of exposure and empathic engagement. As such, a separate model is required for future research because in compassionately caring for the sick, nurses are exposed to trauma and this characteristic of caregiving professions cannot be separated from the demands of nurses’ work environments.

Limitations

This study has a number of limitations. The findings are based on the interpretations of interviews with a convenience sample of nurses working in the same maritime regional district health authority. Due to the nature of the sample, it is possible that nurses in this particular study were not typical of all care providers. Furthermore, the sample size was small due to time constraints on the part of both researcher and potential participants. For this reason, the results may not generalise to all nurses. The sample under-represented males (there was only one male participant). The study also over-represented nurses with more experience (average amount of experience was 15 years). Nurses who have increased exposure to compassion fatigue leave their job. Conversely, nurses high in job satisfaction are probably more willing to participate in such research. For this reason, only a model of job satisfaction was able to emerge from our sample.

In regard to the theme of education and efficacy, it must be noted that six of the nine nurses in the study received their training from nursing school programmes as they have been practicing in the field for some time (15+ years). All six nursing school grads described that today’s novice nurses are very anxious about entering the field, and the nursing school grads do not recall being as nervous. Of course, the accuracy of these statements is questionable due to their retrospective nature; the nursing school grads may or may not accurately remember their experiences as a novice nurse.
Conclusion

In light of the current findings and limitations, it would be useful to interview nurses who leave the profession to see whether compassion fatigue plays a role in their decision to leave. It is very likely that nurses who have suffered from compassion fatigue are no longer in the workplace and therefore the ones who continue to work are the most resilient and thus are over-represented in research findings.

Although demographic factors such as age, years working and education did not appear to be related to levels of resilience in this particular study, it should be further examined. It would also be useful to focus on specialty areas within the nursing profession, such as mental health and palliative care, as they have unique qualities and demands.

The issue of the value of nursing schools should further be explored given that graduates of these programmes feel they are better adjusted to their job and have higher levels of self-efficacy. Although nursing schools no longer exist, today’s licensed practical nurse training programmes are similar to the nursing school model and could serve as a point of comparison with the university degree programme.

Often research regarding stressful work environments makes suggestions for change at the individual level – such as cognitive reframing of situations or using stress-reduction strategies. It is possible that such individual adjustments will not have long-term success if the stressful environment remains unchanged. A more effective approach may require changes at the level of the organisation.

Relevance to clinical practice

The current findings have implications for training programmes and promotion of job satisfaction. Perhaps the most useful implication and solution to minimising discrepancies would be a restructuring of hospital management towards patient-centred care, which would reduce unrealistic expectations of nurses. Ultimately, it is hoped that the information presented can be taken as a step towards improving the well-being of nurses and the quality of their work environments because professionals with compassion fatigue place patients at risk. The understanding of resilience to compassion fatigue is essential for safe and ethical practice.

Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_author.html) as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, and (3) final approval of the version to be published.

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