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INLFUNECE OF DEMOGRAPHIC VARIABLES ON COMPASSION FATIGUE AMONG HEALTHCARE PROFESSIONALS IN IBADAN, NIGERIA

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ABSTRACT

Compassion fatigue (CF), the physical and mental exhaustion and loss of empathy that occurs when caring for sick or traumatised people, is a global phenomenon experienced by diverse categories of healthcare practitioners. In Nigeria, there is a high prevalence of CF among healthcare professionals in both public and private hospitals, due to a complex interaction of factors. This study, therefore, investigated the roles of gender, age, marital status, and job experience on compassion fatigue among healthcare professionals in Ibadan, Nigeria.

Eight hundred and seventy-eight healthcare professionals (238 medical doctors, 547 nurses and 93 allied health professionals) were conveniently selected from eighteen purposively sampled hospitals (federal: 1; state: 2; private: 15) in Ibadan. A 39-item structured questionnaire comprising measures of personal distress (α=0.70), job frustration (α=0.91), work pressure (α=0.81) and compassion fatigue (α=0.75) was administered. The data were analysed using descriptive statistics, t-tests, one-way ANOVA, and hierarchical multiple regression at $p \leq 0.05$.

Participants' age was 36.0 ± 9.51 years; 70.9% were female, while 43.3% were health professionals from the Federal Teaching Hospital (FTH). Age (β=-0.18) and years of experience (β=0.16) independently and jointly (R^2=0.02; F=3.48) influenced CF. Gender and marital status did not significantly predict CF. This indicate that certain demographic factors (age and work experience) also have a significant, though smaller, predictive value. Healthcare organisations should create a conducive workplace environment to mitigate personal distress and compassion fatigue.

Keywords: Compassion fatigue, demographic variables, healthcare professionals, Ibadan, Nigeria

INTRODUCTION

The occupational health and safety of healthcare professionals have become a global concern due to the emotional strain on carers and the need to sustain quality of care (Kandula & Wake, 2021). This underscores the vital role of effective healthcare delivery necessary for maintaining a healthy workforce within any organisation, especially among healthcare providers, as well as the essential systemic support from the government. An implication of this peculiarity is the expectation for a consistent expression of care and compassion by healthcare professionals, as is ideal. However, this expectation is frequently undermined by various factors, including compassion fatigue (Kabunga *et al.*, 2024; Yi et al., 2024). Recent literature highlights that compassion fatigue has become increasingly prevalent, particularly during crises such as the COVID-19 pandemic, contributing to burnout and secondary traumatic stress among healthcare workers (Kabunga *et al.*, 2024; Yi *et al.*, 2024). Systematic reviews further reveal that individual, organisational, and systemic stressors such as high workload, inadequate staffing, and limited support significantly impact the ability of healthcare professionals to consistently provide compassionate care **(**Garnett *et al*, 2023). Despite recognition of this issue, evidence for effective interventions remains limited and inconsistent, indicating an urgent need for more robust approaches to support healthcare providers and mitigate compassion fatigue (Patole, Pawale, and Rath, 2024).

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Compassion fatigue, caused by a combination of burnout and secondary traumatic stress, is increasingly recognised as a widespread issue among healthcare providers, including physicians, nurses, and allied health professionals. This phenomenon has been linked to declines in both practitioner well-being and patient care quality (Smith and Lee, 2025). Compassion fatigue is considered a critical issue for the healthcare professionals (Garnett *et al*, 2023**).** It is characterised as "the natural, consequential behaviours and emotions arising from awareness of a traumatic event experienced by a significant individual" or "the stress stemming from assisting or desiring to assist a traumatised or suffering person" (Ruiz-Fernandez *et al.*, 2020).

Healthcare professionals are generally regarded as a vulnerable group for compassion fatigue and reduced empathy, factors which are closely linked to emotional strain and a stressful work environment (Dowdell *et al.*, 2022; Garnett *et al*, 2023). Recent qualitative research has expanded our understanding of compassion fatigue, describing it as a process that unfolds across multiple psychological stages from initial compassion experience to eventual fatigue highlighting the cumulative and dynamic nature of this condition (Zhang and Wang, 2023). Compassion fatigue often manifests as persistent hyper-arousal, feelings of helplessness, and a sense of disillusionment (Missouridou, 2017), a view supported by newer studies that further emphasize the emotional distress and professional challenges faced by healthcare providers (Zhang and Hui, 2023).

Compassion fatigue is closely linked to stress and burnout, particularly among nursing professionals, and is defined as a state of emotional exhaustion and diminished empathy resulting from ongoing exposure to others suffering (Zhang *et al.,* 2025). Compassion fatigue, particularly the exhaustion resulting from attempts to understand and aid individuals in distress, may result in emotional depletion (Hagen *et al.*, 2025). Recent evidence identifies two distinct components of compassion fatigue: burnout and secondary traumatic stress (Zhang *et al*., 2025). While "compassion fatigue" and "burnout" are often used interchangeably, it is important to note that burnout is primarily driven by external workplace factors, whereas compassion fatigue pertains to the internal emotional experiences of the provider (Mohd Noor *et al*., 2025).

Compassion fatigue may arise suddenly or develop gradually, and can occur in any caregiving context characterised by empathy (Mohd Noor *et al.,* 2025). Healthcare providers, especially those working in pediatric, oncology, and intensive care units, frequently experience this phenomenon (Hagen *et al*., 2025; Yee and Kauric-Klein, 2025). Recent studies indicate that compassion fatigue and related concerns, including burnout, moral distress, and vicarious traumatization, can elicit a diverse range of symptoms in healthcare professionals (Mohd Noor *et al*., 2025; Kim *et al*., 2024). These symptoms can negatively affect interactions with colleagues and patients, as well as performance in patient care (Kim *et al.,* 2024). Manifestations may include physical symptoms (e.g., headaches, gastrointestinal disturbances), emotional difficulties (e.g., depression, anxiety, impaired focus), and professional challenges (e.g., avoidance of specific cases or patients, reduced empathy toward patients and families, frequent absenteeism, and diminished job satisfaction) (Hagen *et al*., 2025; Yee and Kauric-Klein, 2025). Compassion fatigue adversely impacts patient well-being and safety, and may ultimately lead to harmful effects for patients, healthcare organisations, and society as a whole (Pan *et al.*, 2025; Hagen *et al.*, 2025).

Recent data suggests that compassion fatigue is a substantial and pervasive issue among healthcare professionals, with global prevalence estimates ranging from 40% to more than 80%, depending on the care setting and professional function **(**Kabunga *et al*., 2024; Mlaba *et al*., 2023). In Sub-Saharan Africa, the combined rate of compassion fatigue among healthcare workers is above 70%, whereas in Nigeria, mental health professionals report an even higher risk, with more than 75% impacted (Kabunga *et al.*, 2024). Such high rates of compassion fatigue are alarming because they are directly associated with carers' poor well-being, including increased emotional exhaustion, reduced job satisfaction, and a higher risk of absenteeism and turnover (Mlaba *et a*l., 2023). These unfavourable effects have an influence not only on the health and function of healthcare professionals but also on the quality and safety of care provided to patients. In settings such as Ibadan, Nigeria, where healthcare systems are frequently underfunded and

workers are subjected to severe work pressures, the risk factors for compassion fatigue may be increased, making it critical to understand the predictors and implications of this phenomenon.

Given the prevalence of compassion fatigue among healthcare professionals globally, particularly in Nigeria, there is an urgent need to investigate this issue in the Nigerian setting. Compassion fatigue is widespread, with over 70% in Sub-Saharan Africa and more than 75% among Nigerian mental health professionals. It endangers carers' well-being and has far-reaching repercussions for patient care quality and overall healthcare system performance. Understanding the causes of compassion fatigue is critical in resource-constrained contexts like Nigeria, where healthcare professionals frequently experience severe emotional distress, workplace frustration, and work pressure. Such research will provide valuable insights into establishing specific strategies to support healthcare professionals, thus enhancing both carer well-being and patient outcomes. This highlights the need for focused studies on compassion fatigue among Nigerian healthcare professionals (Kabunga *et al.*, 2024; Mlaba *et al.*, 2023).

METHODS

Research Design

Exploratory and cross-sectional research was carried out using a qualitative-quantitative approach with an exploratory sequential design. There were two stages of the investigation. Phase one consisted of gathering qualitative data through focused group discussions and extensive literature review. The results informed the creation and validation of the Compassion Fatigue Scale. Phase two comprised a quantitative cross-sectional survey of 878 healthcare professionals from public and private hospitals. The researcher exclusively recorded information present in the population without altering any variables. The researcher thus described the characteristics that existed in the population as they occurred. Compassion fatigue was the dependent variable, while gender, age, marital status, and job experience were the independent variables.

Setting/Population

The research was conducted in Ibadan, Nigeria. Ibadan hosts the premier tertiary hospital, state hospitals, and other private hospitals. Ibadan is also cosmopolitan in nature with all the expected characteristics of samples and therefore adequate to be used for the study. This research concentrated on healthcare professionals working at federal, state, and private health institutions in Ibadan. The study's whole sample consisted of 878 healthcare workers in Ibadan.

Sample Size Determination

The formula used to determine the sample size was Slovin's formula (1960) with modification by Andale (2012).

Slovin's formula: $N/1 + N\,(e)^2$

Whereby: n is the required sample size.
N is the total population, and e is the error of tolerance (5%).

Slovins formula: $n = \dfrac{N}{1+N\,(e)^2}$ 3.1

Sample Size Calculation for the University College Hospital, Ibadan

The staff enumeration list comprised resident doctors, nurses and allied healthcare providers, obtained from the Human Resource Department records at the University College Hospital, Ibadan. The records of staff enumeration are therefore presented (Table 1).

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Note: Allied health professionals consist of physiotherapists, radiographers, social workers, psychologists, dieticians, and pharmacists for all the hospitals.

$$n = \frac{2110}{1+2110(0.05)^2} \quad \ldots \quad 3.2$$

$$n = \frac{2110}{6.275}$$

n = approximately 337 **(Table 3.1).**
Attrition rate was 10%, hence 10% of 337 is approximately 34.

Table 1: Sample Size University College Hospital, Ibadan

Professional	Total Number as at Date Visited	Minimum Sample in each Unit
Doctors	704	124 $\left(\frac{704}{2110} \times \frac{704}{1} \text{ i.e. } 371\right)$
Nurses	1307	230 $\left(\frac{1307}{2110} \times \frac{1307}{1} \text{ i.e. } 371\right)$
Allied health professionals	99	17 $\left(\frac{99}{2110} \times \frac{99}{1} \text{ i.e. } 371\right)$
Total	**2110**	**371**

Source: Human Resource Department of the University College Hospital, Ibadan

Sample Size Calculation for State Hospitals
All physicians, nurses, and allied health professionals included in the staff enumeration list were considered and obtained from the records of the Human Resource Departments of the two state hospitals (Specialist Hospitals, Yemetu and Adeoyo) (Table 2).

$$n = \frac{427}{1+427(0.05)^2} \quad . \quad 3.3$$

$$n = \frac{427}{2.0675}$$

n = approximately 207
Attrition rate was 10%, hence 10% of 207 is approximately 21.

Sample Size Calculation for Private Hospitals
An average of two permanent doctors were captured and four qualified nurses in the staff enumeration list for each of the private hospitals. Specialist doctors, high-skilled nurses and other allied professionals were consulted and invited on request. Only hospitals with big pharmacies and well-equipped laboratories that offer services for drug dispensing and laboratory services were included. Few big hospitals (15) had more than two doctors and more than four qualified nurses and allied professionals on staff enumeration list. The records of staff enumeration are therefore presented (Table 3).

The sample size determination formula used was the Slovins formula (1960) with modification by Andale (2012).

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n= 464 . 3.4
$1+464(0.05)^2$

n = 464
2.16

n = approximately 215.
Attrition rate was 10%, hence 10% of 215 is approximately 22.

Table 3.2: Sample Size for State Hospitals (Yemetu/Adeoyo), Ibadan

Professionals	Total Number as at Date Visited	Minimum Sample in each Unit
Doctors	76	41 i.e. $\left(\frac{76}{427} \times 228\right)\frac{76}{427} \times 228$
Nurses	323	173 i.e. $\left(\frac{323}{427} \times 228\right)\frac{323}{427} \times 228$
Allied health professionals	27	14 i.e. $\left(\frac{323}{427} \times 228\right)\frac{323}{427} \times 228$
Total	**427**	**228**

Source: Human Resource Departments of the two-State Hospitals

Table 3: Sample Size for Private Hospitals, Ibadan

Professionals	Total Number as at Date Visited	Minimum Sample in each Unit
Doctors	121	62 i.e. $\left(\frac{121}{464} \times 237\right)\frac{121}{464} \times 237$
Nurses	252	128 i.e. $\left(\frac{252}{464} \times 237\right)\frac{252}{464} \times 237$
Allied health professionals	91	47 i.e. $\left(\frac{91}{464} \times 237\right)\frac{91}{464} \times 237$
Total	**464**	**237**

Source: Human Resource Departments of the private Hospitals

Table 4: Summary of Sample Size (Slovin's formula)

Sections	Calculated Sample Size
Uni. College Hospital (UCH)	371
State Hospitals	228
Private Hospitals	237
Total	**836**

**Slovins formula indicated that 836 healthcare professionals would be required for the samples.*

Sampling Technique and Sampling Procedure

The study applied quantitative survey research, employing Slovin's method to determine the sample size of the population. For example, at UCH, there were 704 doctors, 1,307 nurses, and 99 allied healthcare

professionals. At the two state hospitals involved in the present study, there were 76 doctors, 323 nurses, and 27 allied healthcare professionals. For the private hospitals, there were 121 doctors, 252 nurses, and 91 allied healthcare professionals. In all, the total number of doctors was 842, nurses 882, and allied healthcare professionals 217. After establishing the sample size, the multi-stage cluster sampling method was used to select doctors, nurses, and allied healthcare professionals from federal, state, and private institutions in Ibadan. A convenience sampling method was employed to distribute the questionnaires to individuals who agreed or were available to take part in the study.

Competent research assistants were utilised by the investigator to administer the questionnaire. The research assistants had two weeks of training for the current study, notwithstanding their previous competence and experience in supporting prior research initiatives.

Eligibility Criteria

Eligibility for participation in the study requires that a healthcare worker has direct patient engagement. This includes physicians, dentists, nurses, physiotherapists, social workers, pharmacist, psychologists, radiotherapists, radiographers, and dieticians.

Instruments

A questionnaire comprising five scales was employed for data collection in the study. The researcher performed a validation examination of all scales before their implementation in the study. The objective was to assess the existing psychometric qualities and the appropriateness of the instruments for the study.

The employed measures included (1) a dimension of dispositional empathy, namely personal distress (Interpersonal Reactivity Index, Davis, 1983); (2) a job satisfaction/frustration questionnaire (Porter, 1961); (3) a component of the Health & Safety Executive Management Standards Work-Related Stress Indicator, formulated by Edwards, Julian, Simon, Van Darren, and Easton, Simon (2002); and (4) a Compassion Fatigue Scale created by the researcher. A questionnaire was divided into five sections: Section a) Demographic characteristics including gender, age, marital status, work experience, department, and job status; Section b) Personal distress (Interpersonal Reactivity Index (IRI); Section c) Job frustration questionnaire; Section d) Work pressure scale; Section e) Compassion fatigue scale.

The sections are outlined in order:

Demographic Questionnaire

This section comprised queries pertaining to demographic and personal biographical information aimed at collecting data about participants' gender, age, marital status and work experience.

Compassion Fatigue Scale

The compassion fatigue scale measures carers decreased capacity or inclination to empathise with or relive the suffering of others (Figley, 1995). Standardised measures have been created to assess the prevalence of compassion fatigue among clinical practitioners in traumatic environments. Instruments designed to assess compassion fatigue are commonly utilised as screening tools to enhance awareness and inform affected practitioners about effective prevention and self-care strategies (Bride *et al.*, 2007; Stamm, 2010; James and Gilliland, 2013). Figley's self-assessment tool for compassion fatigue was developed to evaluate both compassion fatigue and job-related burnout (Figley, 2002; Boscarino *et al.*, 2010; James and Gilliland, 2013).

The compassion fatigue assessment, derived from the experiences of practitioners and clients of the researchers, comprises 40 items, with scores categorised as low, moderate, or high levels of compassion

fatigue (Bride *et al.*, 2007; Boscarino *et al.*, 2010). Subsequent investigations into compassion fatigue by Figley and associates culminated in a 66-item questionnaire encompassing both positively and negatively phrased items pertaining to compassion fatigue (Stamm, 2010). The Compassion Fatigue Scale-Revised (Compassion Fatigue-R), consisting of 30 items, was created by Gentry *et al.* in 2002 as an alternative version for assessing compassion fatigue. However, no recorded evaluation regarding the validity and reliability of the Compassion Fatigue-R, and research utilising this measure is scarce (Bride *et al.*, 2007).

The researcher created the compassion fatigue instrument for the present study. The pilot research of the nine-item compassion fatigue scale indicated a Cronbachs alpha coefficient of reliability of .66 and a Spearman-Brown coefficient of .69. Hair *et al.* (1988) asserted that an alpha value of .60 or higher is deemed appropriate for a newly established scale. The current validation investigation yielded a Cronbachs alpha coefficient of reliability of .75 and a Spearman-Brown split-half reliability of .71. An elevated score on the scale by healthcare professionals indicates a greater degree of compassion fatigue.

Development and Validation of the Compassion Fatigue Scale

Stage one: Phase one comprised a qualitative exploratory study utilising focus group discussion (FGD). This enabled the researcher to obtain extensive qualitative data concerning compassion fatigue.

Stage two: Stage two entailed formulating questions based on the themes identified in focus Group discussions (FGD), and extensive literature research for the development and validation of the Compassion Fatigue Scale.

Factor Analysis for the Compassion Fatigue Scale

Exploratory factor analysis was utilised. Principal component analysis (PCA) utilising Varimax rotation yielded two factors, exhibiting eigenvalues ranging from 1.5 to 2.4, culminating in a cumulative percentage variance of 44.2. Items 1, 2, 4, 5, 8, and 9 were linked to factor 1, termed 'work burnout' (the feeling of being constrained by professional obligations). Items 3, 6, and 7 were linked to factor 2, labelled 'secondary trauma' (including flashbacks and distressing nightmares related to patient interactions). The 9 items were consolidated to create a work burnout subscale comprising 6 items and a secondary trauma subscale consisting of 3 items. All measures exhibited adequate internal validity, with the Workplace Burnout scale yielding a Cronbachs alpha coefficient of reliability of .60 and the Secondary Trauma scale a Cronbachs alpha coefficient of reliability of .67. The preliminary study of the nine-item compassion fatigue scale produced a Cronbachs alpha coefficient of reliability of .66 and a Spearman-Brown coefficient of .69. Hair *et al*. (1988) asserted that an alpha value of .60 or higher is deemed appropriate for a newly developed scale. The current validation investigation recorded yielded a Cronbachs alpha coefficient of reliability of .75 and a Spearman-Brown split-half reliability of .71.

Items were generated by focus group discussions (FGD), literature reviews, and expert assessments. A total of 45 preliminary items were evaluated for expert assessments. The content analysis results revealed that 24 of the original 45 items received less than 80% endorsement from the experts and were thus dropped. The outputs from these exercises underwent a content validity evaluation (Cronbach, 1971). Items exhibiting 80% or higher consensus among expert evaluations (Nunnally, 1978; Okurame and Balogun, 2005) were assembled into a questionnaire and distributed to field participants to assess reliability and psychometric characteristics. The experts' recommendations were incorporated into the final 16 items for the pilot research. Item-total analysis: After item-total analysis of the results, the 16 items used for the pilot study were reduced to 9 items as a result of weak correlation coefficient of some of the items. A principal component analysis, employing the Varimax rotation approach with Kaiser normalisation, was performed to carry out a factor analysis on the data collected from the pilot study. Items with loadings of .35 or higher (Pedhazur, 1982; Grolombok, 1995) were employed for the final scale implemented in the field.

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The construct validity of the compassion fatigue scale was established by correlation with established instruments, such as the ProQOL (Professional Quality of Life) scale, work burnout scale and a job satisfaction scale, following the methods described by Hayden, 2022. The pilot research of the nine-item compassion fatigue scale indicated a Cronbachs alpha coefficient of reliability of .66 and a Spearman-Brown coefficient of .69. Hair *et al.* (1988) asserted that an alpha value of .60 or higher is deemed appropriate for a newly established scale.

The primary study utilised validated measures administered through a convenience sampling method to individuals who were willing or available to participate at federal, state, and private hospitals in Ibadan. The investigator recruited study assistants to facilitate the administration of the substantial number of surveys and the targeted locations. A total of 1,200 questionnaires were distributed, of which 950 were returned. Following data cleaning, 878 valid questionnaires were used for the analysis, representing a usable rate of 73.2%. The current validation investigation yielded a Cronbachs alpha coefficient of reliability of .75 and a Spearman-Brown split-half reliability of .71. An elevated score on the scale by healthcare professionals indicates a greater degree of compassion fatigue.

RESULTS

Multiple regression is a statistical technique that examines the relationships between numerous predictors and a continuous dependent variable. By methodically including predictors, researchers can manage confounding variables, analyse the individual impact of each predictor or set of predictors, and evaluate hypotheses concerning predictions. This method clarifies variable relationships and determines the primary predictors of the outcome, enhancing understanding of intricate interconnections (Chiou, Bai, and Lai, 2023). Hypothesis posits that gender, age, marital status, and work experience will jointly and independently predict compassion fatigue. (Table 5).

Table 5: Summary of Hierarchical Regression Analysis Predicting Compassion Fatigue (n = 878)

Model	Variables	β	t	p	R	R^2	F	p (F)
Step 1	Gender	.021	0.588	.556				
	Age	-.181	-3.253	.001				
	Marital status	.000	0.004	.997	R_1=.134	R_1^2=.018	F_1=3.488	$p_{(F_1)}$<.01
	Work experience	.166	3.226	.001				

- **p** significant at the 0.01 level.

A multiple regression analysis was performed to evaluate the predictors of compassion fatigue among 878 participants. Demographic variables (gender, age, marital status, and work experience) were entered into the model and accounted for a small but statistically significant proportion of variance in compassion fatigue, $R^2 = .018$, $F (4, 873) = 3.488$, $p < .01$. Among these predictors, only age ($\beta = -.181$, $p = .001$) and work experience ($\beta = .166$, $p = .001$) emerged as significant independent predictors, while gender and marital status were not significant. Hypothesis one is partially supported.

DISCUSSION

Hypothesis one posited that gender, age, marital status, and job experience would jointly and independently predict compassion fatigue. While demographic variables explained a small but significant portion of the variance, only age and work experience were significant predictors suggesting that younger and less experienced individuals may be at greater risk. Healthcare professionals aged 20-30 exhibit increased susceptibility to compassion fatigue, potentially due to inexperience, insufficient resilience, heightened emotional engagement in patient care, and perfectionist tendencies (Muliira & Ssendikadiwa, 2021; Kabunga *et al.*, 2024). Hochschilds Emotional Labour Theory (1983) underscores the psychological toll of emotional labour, especially in professions necessitating strict emotional regulation, such as healthcare. Older healthcare workers (aged 50-60) benefit from enhanced emotional regulation, life experience, perspective, and self-care practices, resulting in reduced compassion fatigue (Afulani *et al.*, 2023).

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Likewise, no statistically significant difference in compassion fatigue was found between male and female healthcare professionals, suggesting that both groups are susceptible (Yusuf *et al.,* 2023). Marital status did not exert a substantial impact on compassion fatigue, corroborating recent findings (Kabunga *et al.,* 2024). Previous studies examining the influence of demographic characteristics on compassion fatigue have produced inconsistent results, but recent meta-analyses show a strong relationship between age, experience, and levels of compassion fatigue, burnout, and secondary traumatic stress (Kabunga *et al.,* 2024; Kase *et al.,* 2018). The interaction of these qualities may exacerbate vulnerability, underscoring the necessity of evaluating various demographic factors to understand and mitigate compassion fatigue. The Social Cognitive Theory (Bandura, 1986) also offers insight, suggesting that self-efficacy and learned coping strategies often developed with experience protect against compassion fatigue. Conversely, less experienced workers may lack these protective factors, increasing their risk.

Conclusion

This study investigated the influence and importance of socio-demographic variables on the compassion fatigue experienced by healthcare professionals in Nigeria. Based on the study's findings and previous research, it is evident that gender, age, work experience, and marital status independently and jointly influenced compassion fatigue. Age and years of experience emerged as significant independent predictors, while gender and marital status did not.

Recommendations

These results are critical for the development of effective workload management strategies aimed at alleviating emotional distress and occupational strain among healthcare providers in Nigeria. Proactively addressing compassion fatigue is essential, as it may impair healthcare workers ability to fulfil their caregiving responsibilities.

The study also identified important considerations for training and professional development across both private and public healthcare settings. Systematic tracking of healthcare professionals' profiles regarding personal distress, workplace frustration, and work pressure is recommended to monitor the emergence and prevalence of compassion fatigue. Left unaddressed, this issue may mask underlying physical and mental health challenges that could escalate into a broader public health concern.

Accordingly, healthcare organisations must raise awareness about compassion fatigue and its psychosocial dimensions. Improving the work environment is also vital: ensuring that proper infrastructure and support systems are in place will enhance healthcare professionals' comfort and performance. Implementing programs that foster a sense of appreciation and belonging among employees can significantly mitigate compassion fatigue. Despite emotional hardship and work-related pressures, healthcare professionals often remain dedicated and find fulfilment in helping others. This intrinsic motivation can serve as a powerful source of resilience, even under challenging conditions.

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