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Experiences of Compassion Fatigue in Doctors: An Exploration of Triggers, Coping Strategies, and Culture

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ABSTRACT: There is currently a growing interest in exploring the effects of Compassion Fatigue (CF) in doctors due to its high prevalence and its association with declines in well-being amongst sufferers, as well as lower quality patient care. This study investigates how hospital doctors experience CF, what coping strategies they utilize, and how culture and medical training influence this. Semi-structured interviews were conducted with seven physicians who represented a range of specialties, years of experience, and cultural backgrounds. Data were analyzed using a hybrid thematic analysis approach. Five a priori (determined prior to analysis) themes and three posteriori (emerged from analysis) themes were identified and analyzed. The a priori themes included: Triggers of CF, Coping Strategies, Signs of CF, Influence of Cultural Background on CF, and Compassion as a Limited and Fluctuating Resource; the posteriori themes included: Lack of Preparation in Medical School, Attitudes About Mental Health, and Triggers of Compassion Satisfaction. Similar triggers and coping strategies were identified in the current study to those in the existing literature. However, the current study builds on this further by highlighting how experiences of CF differed across specialties, years of clinical experience, and cultural backgrounds. The findings suggest that support systems and intervention programs for CF among doctors should be tailored according to some of these factors, which should be an area of focus for future research.

KEYWORDS: Psychology, Health Psychology, Compassion Fatigue, Triggers, Coping Strategies, Culture.

Introduction

Doctors are exposed to suffering and trauma every day, which inevitably impacts their mental health. 62% of medical professionals claim to have experienced Compassion Fatigue (CF) as a result of their job.[1] According to Figley, Huggard, and Rees,[2] CF is defined as a reduction in the capacity or interest in bearing the suffering of others. Recent studies found that CF in medical professionals leads to stress, burnout, and a loss of compassion, resulting in poor quality care.[3,4] CF is also found to be associated with high rates of staff turnover, potential financial implications for healthcare organizations, and concerns for patient safety and the well-being of doctors.[4]

The current study aims to investigate the personal insights of doctors working in public hospitals on the topic of CF. Although there is existing literature exploring the negative psychological, physical, and social effects of doctors experiencing CF, there is a dearth of research regarding the different ways physicians experience CF through in-depth self-report.[5,6] While doctors frequently identify themselves as having experienced CF in survey studies,[3,6,9,14,18,19] the way in which they experience these emotions and symptoms is often unexplored and is likely to vary significantly between individuals. For example, research has shown that doctors' perceptions of compassion are shaped by culture and framing, demonstrating that cultural background and training could profoundly impact how they experience CF.[6] However, no research currently directly explores doctors' personal perspectives on this topic. This highlights the need for an in-depth investigation into the personal experiences of doctors in relation to CF, and in particular their views on the impact of culture.

This study seeks to answer the following research questions: "What are the triggers for doctors experiencing Compassion Fatigue?" "What are the coping strategies used by doctors to manage their emotional well-being?", and "How do culture and medical training impact the experiences of Compassion Fatigue amongst doctors?" These questions are explored using semi-structured interviews with doctors. This study aims to improve understanding of the mental health problems doctors face, better inform the development of strategies to reduce CF, and improve patient and staff well-being.

Literature Review

Currently, the literature is full of inconsistently defined terms. These terms, including burnout, CF, and vicarious trauma, share similar symptoms, resulting in unclear distinctions between them. CF was chosen as the key term in this research as it uniquely captures the emotional cost of caring for others, which many healthcare professionals navigate daily. However, it should be noted that the terms "burnout" and "vicarious trauma" are often used interchangeably with the term CF in the literature, and therefore, research that focuses on these constructs is included in the current review.

A range of individual and organizational triggers has been identified in the literature as contributing to the development of CF in doctors. Exposure to distressing events, including young or traumatic deaths, cases physicians can relate to, and

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witnessing the impact of death on patients' relatives, has been highlighted as impactful.[5] Howard *et al.* discovered that these events were further intensified by the burden of persuasive responsibility, fear of making mistakes, and conflict in the workplace.[5]

However, the literature consistently highlights that CF is also driven by routine events and heavy workloads.[1,2] Small, seemingly insignificant incidents accumulate over time, gradually eroding resilience and increasing vulnerability to stress. These pressures are exacerbated in public healthcare systems, where long hours and heavy workloads predict emotional exhaustion.[9] Research indicates that CF is triggered by the combined effects of acute emotional demands, cumulative routine stressors, and organizational pressures, particularly in contexts characterized by limited institutional support and workplace disempowerment.[9]

Whilst a range of coping strategies and organizational support for doctors' well-being have been identified, substantial barriers to their use remain. Whitebird *et al.* found that healthcare workers experiencing moderate to high stress commonly used coping strategies such as leaning on supportive relationships, engaging in physical activities, and meditation exercises.[10] In particular, working in a supportive team reduces isolation by sharing the burden of care.[10] Healthcare organizations also used certain tactics to promote the well-being of their workers, including encouraging self-care and organizing support groups for stress and bereavement situations.[10]

Nevertheless, previous research has shown that there were punitive outcomes for physicians acknowledging and seeking treatment for mental health problems, including stigma, censure by licensing boards, and removal of patient care practice privileges.[11] Therefore, despite these strategies being promoted in theory, doctors are discouraged from pursuing them in practice.

There has been a recent shift in the focus of research from triggers and coping strategies to how individual perception of compassion shapes experiences of CF. Most current research is based on the assumption that compassion is a finite resource that can run out.[12] However, Gainsburg and Cunningham discovered evidence to suggest that mindsets about whether compassion is limited or unlimited impact people's experiences and behaviors when compassion is required of them.[13] Their work showed that not only did participants with limited compassion mindsets self-report negative associations with compassion, but in experimental conditions, they provided lower-quality social support.[13]

Furthermore, Roskvist and Consedine demonstrated that perceptions of compassion are malleable and can be made either more positive or more negative depending on how the concept was framed to participants before they were asked to rate their views of compassion.[12] The participants exposed to a positive framing rated compassion as more satisfying and pleasurable, while the group exposed to a negative framing rated compassion as more draining and exhausting.[12] These pieces of evidence raise the question of whether differences in cultural background and medical training could influence doctors' understanding of compassion and its impact on their experiences of CF.

Although there is existing literature on the impact of culture/race on the rate of burnout in healthcare professionals, studies have obtained mixed evidence on this matter. Some studies have found that resident physicians in minority racial ethnic groups were more likely to experience burnout,[14] while other studies found the opposite or no difference.[15,16] It has been argued that the conflicting findings on burnout and CF across racial/ethnic groups may reflect qualitative differences in experience that are not consistently or accurately captured by existing measures. For example, research suggests that minority experiences may be shaped by unique stressors or by differences in how such experiences are perceived and reported compared to majority ethnic groups.[13,17] This topic is a crucial area to research for clearer answers, so qualitative semi-structured interviews were conducted in this study with physicians from a range of cultural backgrounds. This approach enables more in-depth and nuanced data to be collected and analyzed, in an attempt to bridge this gap in the literature.

Methods

This study was conducted through semi-structured interviews, aimed at answering the research questions:

1. What are the triggers for doctors experiencing compassion fatigue?
2. What are the coping strategies used by doctors to manage their emotional well-being?
3. How do cultural background and medical training impact the experiences of compassion fatigue amongst doctors?

Recruitment:

Participants were recruited through opportunistic and snowball sampling. Emails were sent to potential participants who were known to/referred to the researcher through a range of personal, academic, and community-based connections.

Consent:

Before interviews were scheduled, participation information and consent forms were sent to all participants for review and signature.

Data Collection:

The participants took part in a semi-structured interview where they were asked to discuss their experiences of CF. The semi-structured approach allowed a set of predetermined topics to be examined, while also allowing new emerging themes to be explored through follow-up questions to participants' initial responses. This flexible approach allowed for nuanced data to be collected, which cultivates a richer understanding of the participants' experiences. All of the interviews were conducted online via Google Meet, recorded, and manually transcribed by the author. The average duration of each interview was 27 minutes.

Data Analysis:

A hybrid approach was used to thematically analyze data collected from interviews. This approach allowed for the identification of themes grounded in the data, while also drawing on ideas present in the existing literature. The researcher first familiarized herself with the data by manually transcribing the interviews and engaging in multiple read-throughs of the transcripts. An initial coding framework was developed based on the existing literature on CF to guide the initial line-by-line coding of the transcripts. The framework, however, remained flexible to the addition of inductive codes that reflected the patterns seen in the data set. This formed part of an iterative process involving moving back and forth between the initial coding framework and the data. The codes were then organized into a broader set of a priori (deductive) and posteriori (inductive) themes based on patterns of shared meaning.[20] Reflexive notes were taken throughout this process to track and review coding decisions. Direct quotes were chosen from the transcripts to illustrate the different themes throughout the results section.

Results

Participants:

Seven participants were interviewed. All participants were male and had a mean age of 43.4 years (range 27-59 years). Participants worked across a range of specialties, with professional experience ranging from 3 to 31 years (mean = 18.6 years). Participants came from a range of cultural backgrounds. All had trained or practiced in the UK during their careers, while some had also trained or practiced in other countries (Table 1).

A priori Themes:

The a priori themes, which were identified before data analysis, were derived from the existing literature and research questions. These themes provided the initial framework to guide analysis.

Triggers of Compassion Fatigue:

Exposure to distressing events at work:

Several clinical events were described as emotionally disruptive and deeply impactful for participants. The events included: death of patients, breaking bad news, assault, and suicide. Dr. 1, an intensivist, noted that the death of younger patients impacted him. He described these incidents as very overwhelming: "If it's a patient who's younger, if it was a kid or, like, the younger they are, the more you would feel".

For surgeons and intensivists, breaking bad news to patients and relatives was identified as particularly difficult. "Speaking to the patient, speaking to their family, it's really, really difficult. It takes a lot of emotional energy from you," Dr. 2 explained.

Assault was identified as a significant factor influencing physicians' levels of compassion, with some participants describing it as a normalized aspect of their work. Dr. 5, a psychiatrist, recollected, "I've been assaulted, my colleagues have been assaulted in the past, and that negatively affects compassion". He further described dreading going to work in the days that followed these incidents.

Participants also described patients and colleagues committing suicide, and how this affected their emotional well-being and reduced their capacity to provide compassionate care. In particular, the suicide committed by a colleague was described as particularly emotionally disruptive. Dr. 5 and 7 noted difficulties providing care while processing the tragedy. Dr. 7, an anesthesiologist, shared,

"We did have one of our colleagues take his own life about 5 years ago during COVID, and he was a chap from the Philippines, and he was away from his family and obviously finding it too much, but there were no real warning signs that anyone was particularly aware of. And it was utterly shocking at the time, and it really had a big impact on a lot of people for a while."

Heavy workload:

Participants frequently described substantial workloads and demanding schedules as factors that diminished their capacity for compassion towards their patients. Many doctors reported working in understaffed hospitals, where they are expected to shoulder the workload of several physicians. Some participants expressed regret at being unable to provide more emotional support for their patients. Dr. 1, an intensivist who worked in the NHS, said, "you're sort of doing the bare minimum for patients because you don't have enough time in the day to focus too much on each of them … there's just so much to do as a doctor, there's an unending amount of work". Similarly, Dr. 4, a urology surgeon working in the NHS, said he is "basically overwhelmed with the amount of work and the amount of responsibilities".

Thinking about patients non-stop:

Participants also described thinking about patients too much as a common trigger of compassion fatigue. Dr. 3, an orthopedic surgeon, said, "If you do any complex case, you are always thinking about that complex case, till everything completely becomes normal [and the patient has recovered]". Dr. 5, a psychiatrist, explained that "you'll get used to it, but you'll get used to it in a bad way, and that's not good for you, and it's not good for your mental health, and it's not good for your patients. There needs to be times when you need to step away from them".

Coping Strategies:

Participants identified several coping strategies that they used to cope with the emotional toll of practicing medicine. A range of methods was used depending on the nature of the events witnessed or experienced.

Building resilience:

All participants described an expectation within medicine that doctors should build resilience to the emotional toll of clinical practice over time. Although they developed other coping strategies, resilience was noted as a fundamental part of clinical development. Dr. 6, a psychiatrist, reported that it was

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seen as "just part of the training, you build resilience and over time, [you] just have tough skin".

Emotional barriers:

Many doctors noted that they create emotional barriers to protect themselves from the emotional toll of their work. Dr. 4, a urologist, explained that "It's not a matter of being insensitive or uncompassionate, but it's just like a coping mechanism to basically carry on with your daily life". Dr. 2, another urologist, stated, "It can be overwhelming otherwise" if there are no barriers in place.

Talking to other medics:

Participants with friends or family members working in medicine emphasized the importance of being able to talk about work-related stresses with those who understand the profession. Similarly, those without friends and family in the profession identified supportive colleagues as crucial to helping them cope. "I've got really nice colleagues, and we talk all the time … That's quite important", Dr. 2 said. Several other participants agreed, expressing how this sense of camaraderie among colleagues has facilitated their learning and supported them emotionally. Dr. 4 also noted that "usually, medical people understand each other more than other people", so he talks a lot with his friends and his wife, who all work in medicine.

Signs of Compassion Fatigue:

Disturbed sleep:

Several participants described not being able to sleep well after working long shifts. Dr. 3, an orthopedic surgeon, said, "When you are sleeping, you suddenly have a dream … that patient or that procedure will come to you". This seems to be the case not only for surgeons but also for psychiatrists. Dr. 6 said, "You can't sleep with your two eyes closed until you retire, you can't". Others also mentioned difficulty with sleep during their rotation in the emergency room in their foundation years due to the severity of the cases witnessed.

Passive desensitization:

Some participants noted that consistent exposure to trauma, regardless of years in the profession, could lead to desensitization and make it increasingly difficult to maintain compassion towards patients. Dr. 3 explained, "The more you're exposed to stuff in medicine, the more effort it takes for you to be compassionate because you get used to the things that you see and experience". Although desensitization may appear to function as a coping strategy, participants noted that they are becoming desensitized passively over time, which differs from using desensitization as an active strategy to promote coping. Dr. 2 noted that while the concern you have for your patients can be overwhelming at times, "the moment that you're not worried about what you're doing to people and the effect that you have on them is probably a time to try and get some help for yourself".

Influence of Cultural Background on Compassion Fatigue:

Cultural variations in the stigmatization of mental health:

Participants born and raised outside of the UK shared the view that there was less mental health awareness in their home countries. They described a lack of support for doctors following traumatic events. Dr. 4 recalled, "Back in my country, really catastrophic things happen, and no one really takes care of that aspect of things; it really takes a toll and keeps a scar in people's minds". Several participants reported that speaking out about personal struggles is frowned upon in their home countries, where mental health is still very much stigmatized. Dr. 6 noted that "there is still some stigma [in Nigeria] … because people are not speaking up." While Dr. 4, who is from Lebanon, stated, "I come from an eastern country where our feelings are looked upon as weakness rather than reality". Dr. 1, who is practicing in Hong Kong, also commented that "the culture, particularly in Asia overall, not just Hong Kong, there's sort of a stigma behind mental health, and it's not talked about too much. It's talked about a lot more these days, but still not as much as in Western counterparts". Contrastingly, doctors from the UK reflected on what they perceived as a growth in the prioritization of mental well-being.

Reduced support systems for immigrants:

Immigrating to other countries impacted the support available to participants. Dr. 6, who immigrated from Nigeria to the UK, noted the lack of support he has now compared to when he lived in Nigeria: "Back home you've got family support, there's community support. I don't really have anyone … you may end up realizing the person you want to speak to is miles away from you". He further explained that seeking support in an unfamiliar country can be particularly difficult, as people who are not connected to your culture or background may find it more difficult to relate to your struggles and experiences.

Compassion as a Limited and Fluctuating Resource:

All participants spoke about compassion as a limited and fluctuating resource. For example, Dr. 2 noted its finite capacity, stating that "we've all got a certain amount of bandwidth that we can expend on things at work, on ourselves, on our family … probably there is some compassion exhaustion for some people when they've got a lot of other stuff going on". While Dr. 7 agreed that compassion can run out, he noted that this occurs only during "brief moments, particularly during shifts, and particularly when you're a resident doctor where you're doing a row of night shifts … because you've just completely run out of energy". Dr. 5 suggested that fluctuations in compassion is something we have control over, believing that "you can influence [your level of compassion] without a doubt, and you can always make it better than it was yesterday or worse than it was yesterday". How one can influence compassion in this way, however, was not established during the interview.

Posteriori Themes:

The posteriori themes were identified inductively from the data during analysis.

Lack of Preparation in Medical School:

All participants reported receiving little to no education during medical school on coping with the stresses of the profession. As a result, they had to develop their own coping strategies. Dr. 3, who trained in India, said that "even now, I'm not sure whether the medical degree in the UK or even in India they teach you how to cope with the failures". This experience was consistent across participants, regardless of differences in attitudes towards mental health in the countries in which they were trained. All participants indicated that having some support during medical school would have helped them a lot.

Attitudes About Mental Health:

Differences across specialties:

Several participants across different specialties noticed differences in how their colleagues viewed mental health. In particular, it was not seen as unusual in psychiatry and anesthetics to check on each other's mental well-being. Dr. 5, a psychiatrist, said "it's not expected, but it's not unusual to always check in with people and to always talk about mental health", while Dr. 7, an anesthesiologist, said "you can always find someone who you're able to talk to and there's often an office, you can go in and have a chat with [colleagues] about what's happening, and most people can do that fairly openly". He thinks this is the case as "the suicide rate amongst anesthesiologists is one of the highest", so they are willing to be more open in an attempt to reduce the rate of self-harm. On the other hand, several participants noted that there is much more stigma in other specialties, particularly General Practice. However, the reason for this difference was not established in the interview.

Improving attitudes about mental health in the UK:

On a more hopeful note, the participants currently working in the UK observed a positive shift in people's views on mental health. Dr. 7 noticed that "there's a much lower threshold to take time to manage your mental health, to seek help, and to alert people when you are feeling that work is getting to you and that you are struggling". Dr. 4 also noted how "people [in the UK] are more in touch with what they feel, and they're a bit more open to share."

Triggers of Compassion Satisfaction:

Multiple participants identified positive patient feedback as a primary motivator for continuing to practice medicine. Dr. 3 explained, "When you see the patient coming back to your clinic saying that, well, you changed my lifestyle … that makes you happy, and that is like fuel for your motivation". Dr. 6 described a similar experience, stating, "When I see my patients get better, when I see them recover, when I see them happier than when they came to me, and most importantly, when I see them being productive as well. That is fulfilling". Similarly, Dr. 1 felt motivated as he knew that "you're doing a lot of good, you're changing a lot of lives". He currently works in the ICU and noted that seeing "how the family of the patients shows so much happiness and gratitude after you've saved their lives" gave him a lot of satisfaction.

Discussion

Discussion

In relation to the first research question, the findings suggest that doctors' experiences of CF were triggered by a range of clinical events and organizational pressures. Exposure to distressing events was also identified as a key trigger in research conducted by Howard *et al.* and Dasan *et al.*, respectively.[3,5] The findings of the current study build on these findings and additionally suggest that the types of distressing events perceived to trigger CF vary somewhat across medical specialties. This could be linked to the differing nature of the types of cases and the role clinicians play in a patient's care within each specialty. For example, a large part of surgeons' jobs includes talking with patients about their diagnoses and treatment plans; therefore, breaking bad news was perceived as a major trigger of CF and emotional exhaustion for these participants. These findings highlight how the emotional demands associated with CF may differ according to specialty-specific clinical experiences.

Limited research has been conducted on the impacts of CF on physicians in different specialties. The current findings raise important questions about the different emotional needs of different specialists, as well as how they could be better supported with suitable care and prevention. In addition, an emergent theme in the data was the perception that attitudes towards mental health differed across specialties, with some having higher levels of awareness and support than others. This implies that interventions aimed at reducing CF may benefit from being tailored to the culture and demands surrounding each particular specialty.

The current study also found that certain organizational factors, such as high-intensity workloads, could trigger CF in participants by limiting their emotional capacity to engage compassionately with patients. This was particularly evident for participants when they were at the start of their careers, when their workload was at its heaviest. These findings support previous research by Dasan *et al.*, who showed that doctors' levels of compassion are reduced when they are frequently exhausted during their training years.[3] Their study also reported that younger consultants reported higher levels of CF, whereas older consultants reported lower levels of CF.[3] A similar pattern emerged in the current study. Consultants more often described experiencing compassion satisfaction triggered by receiving positive patient feedback, while younger doctors focused more on the physical and emotional exhaustion of their work.

While these findings identify workload as a key trigger of CF, they also address the second research question by suggesting that doctors may manage CF through the development of resilience over the course of their professional experience. These findings may indicate that early-career doctors may be particularly vulnerable to CF due to the combination of intensive workloads and limited experience with handling the intense emotional demands of the role. In contrast, greater emphasis on compassion satisfaction amongst consultants may suggest that some doctors become more able to manage these demands over time, through more manageable workloads and

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resilience-building through experience. However, it is important to note that in both the current study and Dasan *et al.*'s study, survival bias may have played a major part in forming this pattern.[3] Those who struggled to cope during residency may be more likely to leave medicine and pursue another career, while those who coped well may be more likely to pursue consultancy roles. To eliminate this possibility, further research utilizing a longitudinal design to follow the trajectories of doctors' careers and their experiences of CF is required.

The lack of training participants received to prepare them for the emotional burden associated with clinical practice may have contributed to the CF they described experiencing within their roles. Despite participants in the current study suggesting that mental health awareness has improved among doctors in the UK, it is evident that improvements are still needed, as this appears not to have translated into tangible support during training. Given that the findings indicate younger doctors struggle more with coping with the stress of the profession, mental health training should be incorporated into the curriculum in medical school. Future research should consider the current barriers to providing relevant training in medical school, given that it has been noted as an issue by participants who had trained in different countries. This could better inform the best form of support to provide.

It is also notable that doctors understood that compassion fluctuated over time, with some even suggesting that these fluctuations could be controlled by the individual. Previous research by Roskvist, Consedine, Gainsburg, and Cunningham supports this finding, demonstrating how perceptions of compassion are malleable and can positively or negatively impact people's experiences.[12,13] This suggests that CF is not inevitable and could be positively influenced by appropriate interventions, further emphasizing the importance of training and support for doctors to help them manage their mental well-being.

In relation to the third research question, the findings indicate that participants' experiences were shaped by the varying levels of mental health awareness and stigma in which they trained and worked. Some participants have trained in a culture of higher levels of stigma around mental health compared to the UK. This may have resulted in reluctance to seek help for mental health difficulties, which aligns with Garcia *et al.*'s conclusion that stigma may reduce disclosure and help-seeking in minority racial/ethnic groups experiencing mental health concerns.[19] In addition, these doctors may have less access to certain coping strategies, such as social support. Dr. 6's comments about not having anyone to talk to and Lawrence *et al.*'s findings support this interpretation, suggesting that doctors coming to the UK from other cultures may be more vulnerable to CF.[16] This lends some support to previous research concluding that resident physicians in minority racial ethnic groups were more likely to experience burnout.[14] As a result, confidential support from external professionals may be helpful for them.

Despite these findings, participants offered limited additional insights into how cultural values shaped people's understanding of compassion and CF. This could suggest that participants may not always be consciously aware of cultural factors that may shape their experiences of CF. This is significant as direct questions about culture did not elicit many insights, implying that participants may not be consciously applying cultural values in their compassionate practice. Nevertheless, this does not rule out unconscious influence. Furthermore, discussion relating to mental health stigma and how changes in support systems impacted CF was mainly driven by participants born outside of the UK. This suggests that cultural influences became more noticeable when participants were able to compare experiences across different cultural systems.

■ Conclusion

This study explores experiences of CF in seven doctors representing a wide range of clinical specialties, cultural backgrounds, and years of experience in the field. The findings of this study built on and helped to corroborate the findings of existing studies, which have investigated the experiences of CF in doctors. Similar triggers and coping strategies were identified in the current study to those in the existing literature. This study has further extended understanding by examining the impacts of culture and medical training on CF. Preliminary evidence was found that suggested both the cultural backgrounds doctors came from and the culture within their specialties influenced their attitudes towards mental health, thus affecting their willingness to seek help when needed. The study concluded that it may be helpful to offer more support to physicians, particularly those who emigrated to the UK, as they may lack social networks and may come from cultures where mental health is heavily stigmatized. Finally, this study identified differences in CF experiences by participants' specialisms and length of time spent in the profession. These findings suggest that younger doctors should be better supported in the early years of training and practice, and interventions could be tailored more specifically to fit the cultures surrounding different specialisms in order to be the most effective. In both cases, implementing structured peer support programs may prove useful in supporting doctors in their work. Without these interventions, the rate of burnout and CF may continue to increase, reducing doctor retention rates.

■ Limitations

While the current study offers some helpful insights into the field of CF, there are several limitations to the study that ought to be acknowledged when interpreting the findings. Difficulties in obtaining access to suitable participants in this study led to a small, all-male sample, significantly limiting the generalizability of the findings. While the study offers interesting preliminary findings, further research with larger, mixed-gender samples is needed to substantiate them. In particular, it is important to recognize that the absence of female participants means the results do not contain insights from female doctors, who may have a range of different experiences with CF.

In addition, while interviews provide valuable insight into personal perspectives, they are insufficient for capturing culturally embedded beliefs that are not easily articulated through self-report. Participants may not have been consciously aware

of such beliefs, limiting the insights possible using this methodology. Methods allowing deeper exploration of less conscious thoughts and opinions are needed for further research.

Furthermore, it is relevant to highlight that all the interviews were conducted by a high school student, and the significant difference in age and experience between the researcher and participants may have resulted in participants being hesitant to go into detail around sensitive topics. This may have been born of a desire not to pass on emotional burden, or of discomfort with revealing details to someone not in the same field. While it is important to acknowledge this as a potential limitation, there were attempts to minimize the power differential through building rapport and collecting informed consent from participants before interviews were conducted.

Further Research Directions

The current study demonstrates that experiences of CF vary across specialties and cultural backgrounds. These results reveal areas where further research is needed, as the data set for this study is very limited. For example, questions raised include: how can doctors in training be best supported in coping with the emotional toll of practicing medicine, and what kinds of support can be provided to doctors practicing outside of their home countries? Longitudinal studies could be conducted to inform the development of support programs for training doctors. Furthermore, focus group discussions, where participants are able to discuss their experiences and opinions through guided conversation, may be a more fruitful method of data collection on how culture influences one's thought patterns and actions.[21] This method allows participants to build on each other's ideas, which may be more effective in capturing implicit data such as shared assumptions and unspoken norms.

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Author

Lea is an A-Level student at the Perse School, Cambridge, with a passion for medicine. She hopes to read Medicine at a UK university, as well as contribute to the field of medical research in the future.

Appendix

Informed Consent Form

Please read the following information sheet, which details information about this research project and what participation in this project will involve. Afterward, if you would like to participate, you will be asked to sign and return the consent form. This consent form is necessary for us to ensure you fully understand the purpose of your involvement and that you agree to the conditions of your participation.

Research project title: Experiences of compassion fatigue and compassion satisfaction in hospital doctors: an exploration of triggers, coping strategies, and the impacts of doctors' cultural backgrounds.

Student researcher: Lea Yuen

Purpose of the project: Due to the prolonged exposure to suffering and trauma healthcare workers face every day, their mental health is inevitably negatively impacted, with a high percentage having reported experiencing compassion fatigue as a result of their job. Figely (2002) defined compassion fatigue as a reduction in the capacity or interest in bearing the suffering of others. It has also been recognized, however, that individuals who work in such conditions can also derive pleasure from doing their work well, defined by Stamm (2010) as compassion satisfaction. Research (Dasan, 2015) indicates that compassion fatigue in medical professionals can lead to stress, burnout, and a loss of compassion, resulting in poor quality care. Thus, this research aims to better understand how hospital doctors experience compassion fatigue and compassion satisfaction, with the aim of helping to inform the development of strategies to reduce compassion fatigue and promote compassion satisfaction. In particular, this research seeks to explore how cultural backgrounds may influence doctors' experience of compassion fatigue, as currently there is a lack of research examining in-depth self-reports of their experiences in this area.

What will I be asked to do?

I am asking for your voluntary participation in an interview as part of my academic research project. The interview will take around 30-40 minutes, but may be much shorter, and will take place on Google Meet at a time most convenient for you.

Risks and Benefits Associated with Participation:

There are no anticipated risks associated with your participation, but it is possible that you may feel some emotional discomfort about the questions asked. If this occurs, you have the right to stop the interview, withdraw from the research at any point, or not answer any specific question. You will be given an outline of the interview questions prior to the interview, which will help you decide if you would like to participate or not.

You will receive no direct benefit from participating in this research, but this research will hopefully contribute to existing literature to deepen our understanding of this topic and improve mental health for doctors.

What will happen to my data?

- The interview will be recorded, and an anonymized transcript will be produced for data analysis.
- You will be sent the transcript and given the opportunity to correct any factual errors if you wish.
- The transcript will be analyzed by student researcher Lea Yuen.
- Access to the anonymized transcript will be limited to Lea Yuen and academic colleagues and researchers with whom she might collaborate as part of the research process.
- Any summary interview content, or direct quotations from the interview that are included in an academic publication, will be anonymized so that you cannot be identified, and care will be taken to ensure that other identifying information is not revealed.
- The actual recording will be destroyed after the transcript is produced and approved by all participants.
- Any variation of the conditions above will only occur with your further explicit approval.

By signing this form, I agree that:

- I am voluntarily taking part in this project. I understand that I do not have to take part, and I can stop the interview at any time;
- I may be directly quoted from the transcribed interview with a pseudonym (made-up name) in the published research;
- I do not expect to receive any direct benefit or payment for my participation;
- I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
- I have been able to ask any questions I might have, and I understand that I can contact the researcher with any questions I may have in the future;
- I have read all of the information above.

If you have any questions about this study, please feel free to contact:

Student Researcher: Lea Yuen
Email: lyuen@perse.co.uk
or
Research Mentor: Mrs. Hazel Knight
Email: hkknight@Perse.co.uk

_____
Printed Name

_____ _____
Participant's Signature Date (dd/mm/yy)