REVIEW ARTICLE

Causes and Consequences of Empathy Erosion in Nurses: A Comprehensive Review

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Abstract

Empathy is the ability to understand, share, and make people feel heard. Clinically, it is crucial for better patient outcomes. Nurses provide that care along with the physical aspects of care through therapeutic communication. However, this close and consistent contact with suffering often depletes nurses of this trait. This review aims to identify its causes, consequences, and possible recommendations for reducing it. Common causes of this erosion of empathy observed throughout the literature from 2020 to April 2026 in PubMed, ScienceDirect, and Google Scholar were short staffing, overworking, and organizational culture. In contrast, consequences included high turnover intent, reduced therapeutic communication, and, therefore, poor patient outcomes. Physiological consequences include cortisol dysfunction, hypertension, and sleep disturbance. Empathy erosion not only affects nurses physically, mentally, and emotionally but also contributes to patient outcomes. On the other hand, this erosion can also lead to better physical care for patients, as they compensate for the empathetic connection they cannot offer. The relationship between moral distress and empathy erosion will also be investigated in depth. Lastly, peer support in small setups, institutional encouragement, and reasonable working hours with sufficient staff can reduce this issue.

Keywords: *Empathy erosion, empathy decline, nurses, burnout, compassion fatigue, and emotional exhaustion.*

INTRODUCTION

Clinical empathy is not an inherent personality trait but a measurable clinical competency encompassing cognitive understanding, therapeutic communication, and a deliberate intention to deliver holistic care [1]. Given that nurses spend more direct time with patients than any other healthcare professional, empathy is essential for addressing physical, psychological, social, and spiritual needs [2, 3].

Studies consistently show that empathetic interactions improve patient satisfaction, treatment adherence, and quality of care. Despite technological advancement, the nurse-patient relationship remains irreducibly human [1, 4-6]. Yet certain factors cause nurses to become less empathetic. These include

- Occupational stress
- Burnout
- Compassion fatigue
- Organizational challenges
- Moral distress

Ultimately, with the increasing demands of the workplace and an unsupportive workplace environment, many nurses experience empathy decline as their survival comes in jeopardy [7, 8]. Many studies point in many directions about what exactly causes this extreme reduction in empathy and the dire consequences that are seen. If and when holistic care is not provided, it affects patients' survival rates [8]. The disease wins, and the healthcare system fails. In the post-pandemic period, the long-term effects of sustained workload, moral distress, and emotional fatigue on nurses are becoming increasingly visible, making empathy a critical topic for examination. Current evidence suggests that changes in empathy are not uniform and may follow different patterns [9]. The table below differentiates between empathy decline and empathy erosion to clarify these patterns and support accurate interpretation of their distinct causes and consequences.

Table 1: Difference between empathy decline and empathy erosion [1].

Features	Empathy Decline	Empathy Erosion
Nature	Temporary decrease in scores	Structural damage to empathy capacity
Pattern	Transient, tied to specific shifts	Progressive, cumulative over time
Metrics	Lower standardized scale scores	Altered behaviors and deep cynicism
Recovery	Reversible with standard rest	Hard to reverse; requires deeper healing
Triggers	Acute work fatigue or heavy shifts	Systemic failure and moral distress

During the COVID-19 pandemic, nurses were placed under intense clinical and emotional pressure while managing infection control, patient care, and public health responsibilities [10-12]. Table **1** identifies the core altered behaviors that nurses showed during COVID-19. They worked in high-risk environments with continuous exposure to suffering, rapid role changes, and limited recovery time. This sustained burden leads to compassion fatigue, further weakening meaningful engagement. High workload and short staffing then reinforce emotional depletion, creating a cyclical pattern

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where empathy is undervalued and contributing to rising trends of empathy erosion in nursing practice [9, 13].

As nurses, forming a humanistic nurse-patient relationship is crucial to provide holistic care [6]. This care not only accelerates recovery but also gives nurses the much-needed job satisfaction. When the nurse shows empathy, it communicates that the patient is a respected and dignified human. As the quality of empathy deteriorates, the standard of patient care consequently declines [3, 14, 15].

Lastly, if we understand the many causes and their multifaceted impacts, we can identify the problems and solve them, since this issue has been observed in various countries, whether they are higher- or lower-income. One prominent factor observed in wealthier countries is leadership failures [16, 17]. Despite this global urgency, nurses remain significantly understudied compared to physicians in this literature [1]. This review will compile and synthesize current evidence on what causes empathy erosion in nurses, what it costs at the patient, professional, and system level, and what can realistically be done about it.

Operational Definition

Clinical Empathy

Clinical empathy (nursing context) is defined as the nurse's cognitive capacity to understand a patient's experiences, emotions, and perspective; the ability to communicate this understanding effectively; and the maintenance of appropriate professional boundaries during patient care, thereby supporting effective therapeutic interaction and clinical decision-making [1].

METHODOLOGY

A literature search was conducted to examine empathy decline and empathy erosion among nurses. Studies were sourced from PubMed, ScienceDirect, and Google Scholar, covering 2020 to April 2026 to ensure recent and post-pandemic evidence. Inclusion criteria comprised peer-reviewed English-language studies involving nurses or healthcare professionals and reporting outcomes related to empathy, burnout, compassion fatigue, moral distress, or professional identity.

REVIEW

Causes

Emotional Exhaustion and Burnout

Emotional exhaustion is one of the major reasons nurses gradually lose empathy in clinical practice [18]. Constant exposure to stressful and emotionally intense situations, especially without enough rest or support, contributes to this. This leaves nurses mentally drained and emotionally detached [19]. COVID-19 pandemic highlighted this issue clearly, as staff shortages and overwhelming workloads pushed many nurses to a point where caring for patients felt more like completing tasks rather than providing patient-centered, compassionate care [20, 21].

Organizational Culture

Leadership style in healthcare settings greatly influences how nurses cope emotionally and maintain empathy toward patients [22, 23]. A supportive organizational culture can look like empathetic managers actively listening and responding to nurses' needs without judgment. Research shows that a supportive organizational culture plays an important role in protecting nurses' emotional wellbeing and helping them continue to provide compassionate care [24]. This makes organizational culture a huge element in maintaining empathy.

Compassion Fatigue and Continuous Exposure to Suffering

A study from China found that many nurses experienced moderate levels of compassion fatigue, while their sense of job satisfaction was only moderate to low [25]. One of the main reasons was working more than 40 hours a week, which left nurses physically and emotionally exhausted [25]. Without adequate recovery time, prolonged emotional labor erodes both the nurse's wellbeing and the quality of care delivered [17, 25].

Moral Distress and Ethical Dissonance: Complex Effects on Nurses' Emotional Responses

Moral distress produces a counterintuitive clinical pattern — nurses experiencing greater ethical strain sometimes demonstrate higher-quality physical care, apparently as compensation for the empathic connection they can no longer sustain [20]. Moral distress is a common and difficult experience in healthcare, usually defined as the emotional suffering caused by knowing the right action but being unable to take it due to institutional constraints [26, 27]. Over time, this helplessness shows up quietly in the patient-nurse relationship — the nurse who hesitates to speak up, who knows their input would help but holds back anyway because policy or insurance makes it pointless to try [28].

A study conducted across different wards in hospitals in Iran found that about 51.2% of nurses reported a moderate frequency of moral distress, while 39.3% reported moderate intensity [20].

Moral distress is a common and difficult component of healthcare [27]. It is usually defined as emotional suffering caused by being unable to take the right action due to constraints [28]. This often leads to negative self-worth or low self-esteem. It is commonly seen with a lack of confidence, negative self-talk, and feelings of inadequacy [29]. This inadequacy shows up in the patient-nurse interaction when the nurse can feel helpless. Even when they know that their input would benefit the patient, they often hesitate or completely stop due to hospital policies or insurance constraints. Moral distress does not always lower the quality of care

provided [30]. Some coping mechanisms have shown a positive correlation between the two. Recent evidence suggests that this apparent paradox may be more helpful in patient-centered care.

Consequences

Increased Moral Distress

Sustained moral distress arises when nurses are unable to act according to perceived ethical standards due to institutional constraints, creating persistent ethical dissonance. This repeated conflict weakens moral resilience and gradually affects professional identity. Over time, nurses may shift from patient-centered care to task-oriented functioning, and care becomes mechanical — nurses complete tasks but lose sight of the person receiving them [29].

Reduced Clinical Competence

During the COVID-19 pandemic, ICU nurses were exposed to heavy workload, moral distress, and emotional suppression. COVID-19 was the time when many factors, such as the unpredictability of the disease, brought mental health issues for the healthcare workers [30]. Kalani *et al.* (2023) showed that moral distress was linked with lower clinical competence in COVID-19 ICU nurses, meaning that when nurses are under ethical and emotional pressure, their ability to provide safe and effective care declines [21]. This matters because reduced empathy can weaken holistic assessment, make clinical judgment less accurate, and increase the risk of errors in patient care.

Psychological Harm and Long-Term Emotional Injury

Repeated pandemic outbreaks, from SARS and MERS to COVID-19, demonstrated that healthcare workers in infectious settings face substantial and cumulative psychological strain [31, 32]. Albaqawi *et al.* found that resilience, compassion fatigue, moral distress, and moral injury are closely interconnected, showing how emotional burden accumulates and undermines both wellbeing and professional functioning [27]. Molala and Downing further highlighted that this distress directly weakens the capacity for holistic, patient-centered care in intensive settings [33]. Together, these findings confirm that prolonged emotional burden erodes professional identity and the quality of care delivered at the bedside.

Higher Turnover Intent and Workforce Instability

Rapid role changes and sustained workload pressure, as seen during COVID-19 redeployments, created significant instability for nurses navigating unfamiliar environments [34]. Kovanci and Atli Özbaş further found that moral distress during early career transitions may increase the risk of leaving the profession altogether [35]. When ethical and emotional strain accumulates without resolution, nurses disengage from their clinical roles, and turnover intent rises.

Beyond Burnout: Biological Consequences of Sustained Empathy Erosion

Cortisol Dysregulation

A shift in nursing is not just physically demanding — it is neurochemically taxing, placing sustained pressure on the same biological systems that regulate mood and stress response [24]. Coupled with this, greater use of cognitive empathy appears protective against compassion fatigue. Supportive organizational climates and positive peer relationships are associated with lower burnout risk, whereas workplace ostracism has the opposite effect.

Sleep Disturbance

Recent evidence demonstrates interrelationships among empathy fatigue, occupational identity, and sleep quality in nurses [36]. In a cross-sectional survey of 224 nurses in China, using the Compassion Fatigue Short Scale, Nurses' Professional Identity Scale, and Pittsburgh Sleep Quality Index, empathy fatigue was positively associated with poorer sleep quality, indicating that higher emotional exhaustion corresponded with worse sleep outcomes. Empathy fatigue was negatively associated with occupational identity, meaning nurses who felt less connected to their professional role also reported greater emotional exhaustion. Additionally, a stronger occupational identity was associated with better sleep quality, indicating a protective effect against sleep disturbance.

Hypertension Risk

According to the 2026 cross-sectional study, 28.9% of participants had elevated blood pressure due to long working hours and insufficient sleep [37]. Studies have shown that many factors, specifically lifestyle, contribute to stress. Although this study is not completely based on measuring empathy erosion, there is a strong link between empathy decline among nurses and working stressors.

Patient-Centered Consequences of Nurse Empathy Erosion

Neural Desensitization and Pain Underestimation

One of the earliest and most concrete consequences of empathy erosion is inaccurate pain assessment, and the mechanism is neurological rather than attitudinal. A 2023 neuroimaging study found that healthcare experience was associated with decreased anterior insula activity, the brain region responsible for processing others' pain as one's own, and this effect was specific to pain and independent of how it was presented [38]. The clinical implication is significant: the nurse is not choosing to underestimate pain. Their brains have been gradually recalibrated by exposure to stop registering it with the same urgency.

Patient Perspective Gap

Recent literature on patients' perspectives on missed nursing care using a mixed-method survey and interview

of 143 nurses and 643 patients showed that safety-critical tasks were rarely missed; however, tasks that provided holistic care, such as timely support and therapeutic communication, were often omitted [39]. This difference in perspective was only possible with patient interviews, which showed that resource imbalance, workload, and prioritization were key factors causing this missed care. This study suggests a clear, substantial gap between patient expectations and provider priorities, underscoring the need for integrated care models that balance clinical efficiency with perceived compassion.

Paradoxical/Short-Term Functional Consequences of Empathy Erosion

Table **2** shows us that under constant stress, nurses may experience decreased emotional participation, which can provisionally enhance emotional control, task completion, and work productivity. However, these benefits do not last long. They have adverse effects on nurses. This clarifies why the deficit of empathy is not immediately visible. Eventually, it compensates at the expense of the patient, nurses' professional self-concept, and their mental and emotional wellness.

Table 2: Short-term functional effects of empathy erosion *versus* long-term consequences [2, 3, 22, 24, 29, 31, 33, 40].

Dimensions	Short-Term Functional Effect	Long-Term Consequence
Emotional load	Reduced emotional overwhelm	Emotional numbness, depersonalization
Work performance	Faster task completion, procedural focus	Decline in holistic patient care
Coping style	Psychological self-protection	Compassion fatigue & burnout
Patient interaction	Efficient but emotionally neutral care	Patient perspective gap & dissatisfaction
Professional self-view	Sense of control	Progressive professional identity loss
Sustainability	Appears adaptive under pressure	Unsustainable; leads to psychological strain

In essence, emotional suppression acts as a short-term coping mechanism that, without intervention, gradually becomes chronic disengagement.

Sustainability Issue

A cross-sectional study [40] conducted on 400 fixed-term contract nurses in Spain showed that high rates of burnout and low work engagement are inversely linked with temporary jobs. This burnout led to decreased delivery of empathetic care [39]. More importantly, it was noted that burnout also affected nurses' sociability and self-efficacy. Increased intent for turnover was prominently observed. These rapid hiring-and-firing cycles not only increased stress and burnout for nurses but also resulted in decreased humanized care and engagement with the patient, as displayed in Table **3**.

Professional Identity Loss

Current literature highlights the relationship between empathy and professional identity [41]. Validated psychometric instruments and a moderated mediation model were used on 226 Chinese junior male nurses, showing a significant positive relation between the two factors, *i.e.*, empathy and professional identity. Emotional intelligence was identified as a partial mediator, emphasizing that empathy enhances professional identity through improved emotional processing. Empathy is considered the key determinant of professional identity in early nursing practice, with factors such as motivation strengthening this relationship. In summary, empathy erosion is a cascading issue caused by psychological, clinical, and organizational factors rather than an isolated single-factor issue.

Table 3: SWOT analysis [1, 3, 9, 11, 22, 24, 26, 31, 39].

Strengths	Weaknesses	Opportunities	Threats
Emotional control in high-pressure situations	Weakened therapeutic nurse–patient relationships	Training to balance professionalism with empathetic engagement	Long-term emotional detachment becoming habitual
Task-focused, efficient, and timely patient care	Reduced emotional connection with patients	Reflective practices to safely reconnect with emotions	Decline in holistic and patient-centered care
Less emotional vulnerability during emergencies and critical events	Lower patient satisfaction and perceived compassion	Organizational support for emotional regulation skills	Ethical conflicts and moral distress
Improved decision-making without emotional interference	Risk of depersonalized care	Leadership programs promoting compassionate professionalism	Increased turnover due to unresolved emotional strain
Greater psychological resilience	Suppressed emotions contributing to burnout	Research-guided interventions to prevent long-term erosion	Negative impact on healthcare quality and trust

DISCUSSION

This body of literature makes clear that empathy erosion does not follow a straight path — it builds, layer by layer, from stressors that rarely act alone. Across studies, a familiar pattern repeats: nurses stretched thin by understaffing, unsupported by leadership, and given no room to recover from the weight of patient suffering begin losing something they cannot easily name — and eventually cannot easily recover. Left unaddressed, what starts as emotional exhaustion—manageable, even temporary—can calcify into something far harder to undo: empathy erosion.

The literature reveals a clear domino effect: task-oriented culture, sustained exposure to suffering, and burnout converge into empathy erosion when institutional support is absent. Notably, even a single persistent organizational stressor appears sufficient to initiate this trajectory, suggesting that no threshold of co-occurring factors is required for the process to begin. Table **3** shows that these elements appear in patients before they show their damage in nurses. This risk of

depersonalized care and reduced patient satisfaction is the fastest indicator to check if a nurse may be silently fighting this battle.

There have been consistent results throughout the literature; however, an important aspect to note is the paradoxical consequences of moral distress and ethical dissonance on empathy erosion. Empathy erosion is often used as a protective detachment from patients because standing up against institutional policies increases the risk of unemployment; however, it is also notable that nurses, even when feeling empathetic toward a patient, may not express it due to constraints that cause moral distress and ethical concerns. Short-term improvements in physical care can be achieved through compromises nurses make to their morals due to institutional constraints. This diligence in providing better physical care, however, puts their professional identity and job satisfaction in harm's way in the long-term perspective, while considerably escalating their rate of turnover. Even a single unaddressed organizational stressor can set the trajectory toward empathy erosion.

This is not a problem confined to any single region. It appears in Chinese ICUs, Spanish emergency wards, Saudi hospitals, and Tanzanian tertiary centers alike—though what drives it and how it is named differ by context. Physicians and allied health professionals face similar pressures. Still, nurses' continuous, bedside presence — with patients and their families, through suffering and death — places them at the sharpest edge of emotional exposure.

Empathy erosion often results from standing up against institutional policies, which increases the risk of unemployment. It is also notable that nurses, even when feeling empathetic towards a patient, may not express it due to constraints that cause moral distress and ethical concerns.

A clear pattern was also observed among nurses working in wards with higher patient loads or critically ill patients, such as ICUs, Emergency Departments, Oncology, *etc.* Considering the literature, we can conclude that even if a single element, such as workload, is present, it is possible to suspect a nurse of empathy erosion regardless of the presence or absence of other factors. Each factor can stand alone and cause a nurse to experience empathy erosion if sufficient resources are not provided on time.

The possible mechanism behind this strange but common phenomenon is a task-oriented workplace culture instead of patient-centered care, suboptimal hiring, and poor compensation for the work that nurses do. Table **2** shows that even when this strange phenomenon occurs, it still does not provide many long-term benefits. Though short-term benefits are noticed, the long-term losses are dire.

DIRECTIONS FOR FUTURE RESEARCH

Future researchers can explore the impact of post-patient-centered care on nurses and optimal compensation with adequate time off to recover in the long run.

LIMITATIONS

- Heterogeneity of study designs, sample sizes, settings, and measurement tools (*e.g.*, varying empathy and burnout scales) limits comparability and synthesis.
- Scarcity of direct physiological evidence linking empathy erosion to outcomes such as cortisol levels or hypertension, leading to reliance on indirect measures from stress and burnout literature.

RECOMMENDATIONS

Because the damage to the nurse's empathetic capacity is structural, it is incredibly difficult to reverse. Standard time off is insufficient; reversing erosion requires deep psychological recovery, moral injury healing, and comprehensive modifications to the hospital's workplace culture.

Primary Care Setup

Implement Peer-Led Reflection and Moral Resilience Circles: Set up frequently scheduled debriefing meetings for primary care nurses where they can address accumulated ethical problems, uncooperative team dynamics [28], and the ongoing difficulty of resource shortages. These meetings should be designed to strengthen moral resilience, directly interrupting the pathway where ignored moral distress damages a nurse's professional identity and leads to compassion fatigue [24].

Redesign Workflows for Relationship-Centered Care: Modify clinic scheduling metrics away from rigid, high-volume patient quotas to allow for extended consultation times. Reducing this daily clinical friction directly improves the nursing organizational climate [4]. This structural change helps protect the empathy levels of newly employed staff [11] and reduces acute workload stress, which is known to jeopardize patient safety [14].

Tertiary Care Setup

Deploy Embedded Clinical Psychologists for Acute Units: Place mental health specialists directly inside high-acuity, emotionally draining departments such as the ICU or emergency department. This supports immediate intervention and psychological debriefing soon after traumatic incidents or profound ethical dilemmas [29]. Tackling acute psychological distress and moral injury at the bedside stops these conditions from becoming permanent empathy loss [1, 18, 34].

Enact Structural Workload Ceilings and "Caring Rotations": Mandate safe nurse-to-patient ratios alongside structured rotational systems that temporarily shift staff out of high-stress, sub-intensive, or intensive

care environments [15, 19]. Capping extreme operational demands protects nurses from severe compassion fatigue and burnout [23, 25]. It provides the necessary recovery time to protect their clinical competence [33] and maintains high-quality humanistic patient care [9].

CONCLUSION

Reversing empathy erosion requires reframing it as a system failure, not a personal one, and building interventions at the level where the damage actually originates. Empathy erosion in nurses is a serious issue that not only affects the quality of nurse-patient relationships but also the massive healthcare industry, as nurses play a core and indisputable role in its stability. Unchecked occupational pressure does not plateau — it compounds, and what begins as fatigue can end as permanent detachment from the very work that drew nurses to the profession. Healthcare systems that continue treating empathy as a personality trait rather than a professional resource will keep losing it — quietly, steadily, and at great cost to everyone involved.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

ChatGPT and Grammarly were used to help refine sentence structure, grammar, clarity in the manuscript, and organization of the reference list according to journal requirements. All literature selection, interpretation, synthesis, and conclusions were conducted independently by the authors.

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