Experiences of suffering among nursing professionals during the COVID-19 pandemic: A descriptive qualitative study

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ABSTRACT

Background and aim: Healthcare professionals have played a fundamental role in managing and controlling the COVID-19 health crisis. They are exposed to high levels of suffering, trauma, uncertainty, and powerlessness in the workplace. The objective of this study was to explore and understand experiences of suffering among primary care and hospital care nurses during the COVID-19 health crisis.
Design: This is a descriptive qualitative study. Between March and April 2021, 19 in-depth interviews were carried out with nurses at health and social care facilities and hospitals in southern Spain. ATLAS.ti 9.0 software was used for discourse analysis.
Results: Nurses reported that they had experienced suffering during their work in the pandemic. The main causes suggested were direct contact with patients' suffering and organisational difficulties. The repercussions are in emotional dimension and physical deterioration and social isolation.
Conclusion and implications: Given the circumstances, programmes to promote healthy, compassion-based behaviours and changes to the way in which professionals' suffering is handled must be implemented by healthcare facility managers. Nursing leaders should consider the management of suffering as a matter of the first order, both from the ethical point of view and the business profitability and make compassionate leadership.

1. Introduction

Coronavirus disease (COVID-19) is an infectious disease caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Uddin et al., 2020). In 2020, the World Health Organization declared the disease a pandemic posing a serious threat to public health (Muz & Erdoğan Yüce, 2020). This novel viral infection did not discriminate between countries (Galiana et al., 2017). Spain has been one of the most affected countries by the coronavirus in the world, with a mortality rate of 4.8 % and 102,541 deaths to date (Ministry of Health, 2022).

Healthcare professionals have played an important role during the pandemic (Rose et al., 2021). They have had to work under in high-risk conditions, making them one of the worst affected groups in healthcare settings (Eftekhar Ardebili et al., 2020). At all levels of the healthcare system, professionals have worked in extreme conditions with an excessive workload and resource shortages (Bennett et al., 2020). In primary care (PC), healthcare professionals have had to care for infected patients and relatives in their homes and in health centre (Halcomb et al., 2020). They have also provided follow-up after hospital discharge, contact tracking and tracing, screening tests in the community, monitoring of vulnerable COVID-19 patients, and community health education (Verhoeven et al., 2020; Yi et al., 2020). In addition, nurses working in hospital care (HC) have had to care for COVID-19 patients in a critical condition and support suffering and death among patients in isolation

(Fernandez et al., 2020; Morley et al., 2020).

Nurses have faced situations of intense stress and suffering in the workplace, where their integrity has been threatened, they have felt powerless and lacked the personal and psychosocial resources to deal with them. Fear of infection of themselves or their loved ones, insecurity in response to new situations, and trauma experienced while caring for patients have affected professional quality of life and given rise to occupational syndromes (Halcomb et al., 2020; Yi et al., 2020). These situations have affected their physical and mental health and their personal, professional, and social lives (Alharbi et al., 2020; Ohta et al., 2020).

Stamm (2010) identified positive and negative aspects influencing professional quality of life. Positive, protective aspects include compassion satisfaction, which may be defined as an individual's satisfaction at helping to alleviate suffering. Meanwhile, compassion fatigue and burnout are among the negative aspects. Compassion fatigue occurs due to a lack of compassion skills in the presence of high levels of suffering (Figley, 2002; Ruiz-Fernández et al., 2020), whereby compassion is understood as a sensitivity and receptiveness to suffering and a desire and intention to alleviate it (Brito-Pons et al., 2019). This lack of compassion skills can have a serious impact on personal well-being and on fulfilment of the nursing role, resulting in psychological exhaustion, physical exhaustion, and anxiety (Kase et al., 2019).

During the pandemic, nurses have played a vital role in guaranteeing the quality of care and community health (Halcomb et al., 2020). Studies show that compassion fatigue among nurses in different healthcare settings has increased considerably due to high levels of exposure to suffering, continual changes, and the use of coping strategies (al Barmawi et al., 2019; Ruiz-Fernández et al., 2020; Yi et al., 2020).

In short, PC and HC nurses have been subjected to excessive suffering in the workplace and have experienced compassion fatigue (Ruiz-Fernández et al., 2020). Understanding this phenomenon will allow us to address the root cause and systemic issues behind the nurses' suffering as well as to propose intervention programmes to build or reinforce compassion skills based on nursing professionals' experiences during the pandemic (Ortega-Galán et al., 2021). The aim of this study was to understand and describe experiences of suffering among nurses at different levels of the healthcare system during the COVID-19 health crisis.

2. Methods

2.1. Design

This study used a descriptive qualitative design. This design allowed us to understand and describe the suffering experienced by nurses when caring for healthy and ill individuals at different levels of healthcare during the COVID-19 health crisis (Doyle et al., 2020).

2.2. Participants

The participants were nursing professionals from different levels of the healthcare system in the provinces of Almería and Huelva in southern Spain. Professionals were selected using an intentional sampling technique (snowball sampling), allowing participants who were able to report on experiences related to the study objective to be recruited. The number of participants was determined by data saturation. The inclusion criteria were as follows: (1) nursing professionals working in PC or HC settings during the COVID-19 health crisis who cared for patients directly; (2) nurses from basic PC teams (BPCTs), nurses in charge of a patient in hospital settings, or nurse case managers (NCMs) at both levels of the healthcare system. The exclusion criteria were the following: (1) professionals holding management positions during the pandemic; (2) individuals who refused to participate. For the selection of participants, the principal investigator contacted the care coordinators of different primary care and hospital care facilities in both

provinces, who identified potential participants at their respective facilities based on the inclusion criteria. The principal investigator sent an email to the participants inviting them to participate in the study.

Fifty-two nursing professionals were invited, of whom 28 replied and 11 declined. A total of 19 professionals were interviewed (16 women and 3 men). Their mean age was 43.74 years old (SD = 13.16) (Table 1).

2.3. Data collection

Open in-depth interviews were used for data collection. The interviews were conducted between March and April 2021 via videoconference on the Microsoft Teams platform. The sessions were audio recorded after participants had signed the informed consent form. The average length of the interviews was 40–60 min. The interviews began with an open question, although the researcher had an interview guide to follow. Table 2 shows the interview process.

2.4. Analysis

The interviews were recorded, transcribed, and incorporated into a hermeneutic unit in ATLAS.ti 9.0 via inductive analysis (Fernández-Sola et al., 2020). A content analysis of the responses given by the participants was carried out following the steps described by Graneheim and Lundman (2004). Two researchers read the responses individually in order to obtain a general idea. Subsequently, the two researchers individually reread the responses, pointing out the text fragments (words or sentences) that were considered units of meaning. Disagreements were resolved by reaching a consensus through joint discussions. The units of meaning were then labelled and grouped into codes based on their content. The codes were then compared based on similarities and differences and, after discussion and review by the researchers, a consensus was reached on the final grouping of the codes into categories. Finally, the categories were grouped into the three main themes identified through an interpretative process conducted in group meetings.

Different strategies were used to ensure the credibility, reliability, confirmability, and transferability of the data (Lincoln & Guba, 1985): the participation of two researchers in the identification of the units of meaning, consensus meetings held by the researchers throughout the coding and grouping process, as well as the comparison of the results obtained against other well-known studies and data.

Finally, confirmability was achieved by asking participants to validate the results. All participants were offered a chance to do so, but only 9 accepted. The researchers read the interview transcripts, which were sent by email independently before reaching an agreement.

2.5. Ethical considerations

Approval was obtained from the Research Ethics Committee (EFM 112/2021). Participants were informed about the study objectives before signing the informed consent form. The confidentiality and anonymity of participants were preserved at all times in accordance with the Spanish Organic Law 3/2018, of 5 December, on Personal Data Protection and Guarantee of Digital Rights. The data were not used for any purposes other than those set out in the study objectives. The study adhered to the ethical standards set out in the Declaration of Helsinki (World Medical Association, 2001).

3. Results

An analysis of the data revealed 2 themes and 4 subthemes relating to nurses' suffering while delivering care during the COVID-19 health crisis (Table 3).

Table 1

Sociodemographic data relating to the participants.

Participant	Age	Sex	Marital status	Employment status	Years of service	Years in current position	Workplace
P-1	57	Male	Married	Statutory	33	33	BPCT
P-2	30	Female	Married	Temporary	8	3	BPCT
P-3	56	Male	Separated	Statutory	10	3	BPCT
P-4	25	Female	Single	Temporary	2	1	BPCT
P-5	24	Female	Single	Temporary	3	1	BPCT
P-6	57	Male	Married	Statutory	31	30	NCM PC
P-7	56	Female	Married	Statutory	35	3	BPCT
P-8	29	Female	Single	Temporary	7	1	NCM PC
P-9	45	Female	Single	Temporary	20	6	BPCT
P-10	60	Female	Married	Statutory	36	3	BPCT
P-11	53	Female	Married	Statutory	21	21	BPCT
P-12	27	Female	Single	Temporary	1	1	BPCT
P-13	52	Female	Single	Statutory	30	29	Obstetrics
P-14	46	Female	Married	Statutory	25	15	Internal Medicine/Infectious Diseases
P-15	56	Female	Married	Statutory	31	18	Obstetrics and Gynaecology
P-16	32	Female	Single	Active	6	2	Internal Medicine/COVID-19 Ward
P-17	56	Female	Single	Statutory	32	31	Haematology/Oncology
P-18	46	Female	Divorced	Statutory	25	11	COVID-19 Ward
P-19	24	Female	Single	Temporary	2	0	ICU

Note: BPCT = Basic Primary Care Team; NCM PC = Nurse Case Manager in Primary Care; ICU = Intensive Care Unit.

Table 2

Interview guide for the interviews.

Stage of interview	Objective	Content and sample questions
Introduction	Our intentions	I belong to a research group investigating compassion fatigue among primary care nurses during the COVID-19 health crisis. Finding out about your perceptions would be useful to allow us to identify (...)
	Information and ethical considerations	We need to record the conversation so that the research team can analyse the data. Only the research team will have access to the recordings. Your participation is voluntary and participants are entitled to withdraw from the study at any time. Your identity will be protected and your name and personal data will not be given to any third parties.
Opening	Consent	Signing the informed consent form and verbal acceptance.
	Opening question	As a nurse, please describe the impact that witnessing people's suffering during your day-to-day work has had on you.
Continuation	Guided conversation	How would you describe the suffering of the people you care for? Has your nursing work been affected? In your opinion, how important is it to put yourself in the patient's shoes? What do you think you need in order to engage with suffering in a healthier manner? How do you respond to a person who is suffering? How do you feel after supporting a person who is suffering? Do you feel that there are aspects of your work that limit your ability to be empathetic or compassionate with patients and/or yourself?
	Final question	Is there anything else you would like to add?
Close	Acknowledgement	Thank you for participating. Your thoughts will be used for our research study. Please contact us if you need anything. You will receive a copy of the finished study.

Table 3

Theme, subthemes, and codes.

Theme	Subtheme	Codes
What caused nurses to suffer during the COVID-19 pandemic?	Continuous contact with other people's suffering	Traumatic situations, patient demands, the impact of the pandemic, uncertainty, fear/lack of information, stress, suffering, suffering of family members, the impact of COVID-19 after-effects, difficulty providing care.
	Organisational difficulties	Prioritising care, moral responsibility, controlling fear, lack of self-compassion, normalising the situation, alleviating suffering, empathy, affective empathy, active listening, compassion, changes to care, emotion management, courage.
Repercussions of suffering for professionals	Emotional dimension	Anxiety, psychological exhaustion, mood, frustration, emotion management, helplessness, fear of infecting their family members, fear of contagion, compassion satisfaction, sadness.
	Physical deterioration and social isolation	Social exclusion, exhaustion, loneliness, emotional shutdown, rejection.

3.1. Theme 1. What caused nurses to suffer during the COVID-19 pandemic?

Many social and organisational factors caused suffering among nurses during the global pandemic. Contact with patients' suffering and patients' demands while receiving care were the most intensely and frequently expressed factors. Major organisational problems lasting for long periods in different healthcare settings were also identified as a significant source of distress and suffering by the participants.

3.1.1. Subtheme 1. Continuous contact with other people's suffering

During the interviews, the participants clearly stated that the main source of suffering and distress was their contact with patients' suffering during the care delivery process. The impact of the pandemic on people and their personal, professional, family, and social lives was visible on an ongoing basis as nurses cared for those affected. Care delivery was

completely reoriented to focus primarily on alleviating the impact of the pandemic.

> "*You take all that suffering home with you, and although you try, it's inevitable, it stays with you, your experiences with patients stay with you and you say: 'God, it's impossible not to take it [home]'*"
>
> (P3)

> "*You put yourself in their shoes and you think: 'My god, they're my age or younger and look at the state they're in' and they tell you their stories. In that regard, you suffer a lot, and with elderly people too who seem very alone and tell you about their problems*"
>
> (P6)

The participants also explained that patients' requests and demands, as well as their disrespect, demanding, challenging and, at times, disrespectful behaviours that could not be fulfilled by nurses, were an additional cause of suffering. These behaviours led to aversion among nurses and prompted them to seek to set clear limits and distance themselves from these situations.

> "*In some cases, the most difficult thing [in my work] is that [patients] exaggerate their symptoms to try and get something. At some points, that made me feel a bit of an aversion towards them*"
>
> (P11)

> "*You look a bit further than the patient and you have the family, and you try and resolve all their problems and questions, even things that their nurse should maybe be doing. You try to do it yourself to save them from struggling to access the healthcare system and then they demand more and more and more... And something that was just a favour becomes a constant demand and you have to set limits and say 'That's enough! No!'*"
>
> (P9)

3.1.2. Subtheme 2. Organisational difficulties

The participants described major changes to care delivery in PC facilities. Once based on promoting health and preventing illness, and already experiencing numerous difficulties, PC was adapted in response to demand to focus on COVID-19 testing and tracing, overlooking all other procedures. Despite this change, which brought its own ethical and moral burden due to the sidelining of other care needs, demand outweighed the number of professionals available. The participants explained that they felt overwhelmed and pushed themselves to the limit, placing huge demands on themselves because they had no other choice.

> "*You can take it one way or another, but you feel you have an obligation or a moral responsibility to be there, supporting [patients] because they're ultimately alone*"
>
> (P5)

HC professionals said that organisational changes had forced them to leave their former departments and start working in new sections of the hospital. In addition, the COVID-19 measures changed the way in which wards operated: family visits were restricted, professionals' entry to rooms was controlled, etc. Leaving colleagues, patients, and departments where they had worked for years and were comfortable was a source of suffering for nurses. The type of procedures required also radically changed the care delivered and the hospital setting.

> "*It was a huge change for our maternity unit because our ward receives a lot of visitors, a lot of companions, lots of people visiting, it was meant to be a happy ward*"
>
> (P13)

> "*I had a very bad feeling for a few days, well... it lasted a long time. A sense of guilt, abandonment... it still gives me a lump in my throat [becomes emotional] (...) I felt out of place, as if I wasn't where I was meant to be*"
>
> (P15)

3.2. Theme 2. Repercussions of suffering for professionals

3.2.1. Subtheme 1. Emotional dimension

Depending on the nurses' experiences of suffering, the repercussions were both positive and negative. Nurses exhibited generalised psychological exhaustion as a result of the stress and emotional burden of patients' experiences during the pandemic. They described working as hard as they possibly could, feeling that only they could help. They explained the anxiety they suffered from living in a constant state of alertness and tension, as well as their frustration, fear, and powerlessness at being unable to solve or avoid problems, and their sadness.

> "*It wears you down, that's right, but there's also sustained suffering. Initially, it was an anxious response to an unknown situation that gave way to a more or less controlled fear, and now it's fatigue, fear.*"
>
> (P7)

> "*You feel, well, sad, in the end it's sadness, you feel sad. You feel like you could perhaps have done more, helped more. You always think you can do more, but you have a certain amount of resources and time, and you say: 'I can't do any more than I'm doing, I can't, I haven't got time, I haven't got the resources'*"
>
> (P3)

However, most of the participants explained that this suffering was compensated by the satisfaction they felt on other occasions. They felt fulfilled by their work when patients expressed their gratitude and when they were able to acknowledge the huge efforts they had made and their strength and ability to do their best even in extremely difficult circumstances. They described it as a protective mechanism, relieving the suffering and tension triggered by traumatic stress.

> "*Pff, just imagine. As a nurse, it's just the best, it makes me feel complete. It's indescribable. You feel so important to them. Their gratitude, their tears of joy, it's the best thing about nursing*"
>
> (P2)

> "*I'm really satisfied with how hard I worked during the pandemic*"
>
> (P16)

> "*Gratitude... well, you feel good. It's a feeling that, I don't know... it's difficult to describe... (...) it's comforting, it makes you feel good*"
>
> (P6)

3.2.2. Subtheme 2. Physical deterioration and social isolation

The participants coincided in acknowledging the physical deterioration they had experienced, with exhaustion, chronic fatigue, and muscle tension emerging as the most common outcomes.

> "*Physically, I think we all felt it in the end. You're physically tired and you somatise. I might not be that physically tired, but I feel exhausted*"
>
> (P3)

They emphasised the loss of ability to perform a number of activities of daily living, leading to isolation and solitude. Sometimes, they felt misunderstood, while at other times, people viewed them as vectors of the virus due to their work.

> "*I spent two months travelling by bike and I'm tired, I can feel it. Now I get home and all I feel like doing is having a beer because I get home late. [What I do is] eat and then lie down on the sofa and 'good night'. I've been like that for two months*"
>
> (P7)

Professionally speaking, some participants expressed a desire to quit their jobs or request a period of leave, or a need for imminent holiday due to their overexposure to traumatic events since the start of the pandemic.

"*Those who couldn't haven't quit and they've [stayed] put holding the fort and putting up with loads of insults from patients. It's understandable, I understand it because they were fed up with waiting for so long for appointments*"

(P2)

4. Discussion

The aim of this study was to understand the experiences of suffering among nurses at different levels of the healthcare system during the COVID-19 health crisis. Adopting a phenomenological approach allowed us to gain a more in-depth understanding of nursing professionals' experiences of suffering. The results point to two broad themes: causes of suffering and repercussions for nurses during the pandemic. One of the main findings is that nurses were exposed to high levels of suffering for a prolonged period of time due to their close contact with patients' suffering, among other causes (Arcadi et al., 2021).

This was exacerbated by excessive demands from patients and the limitations of the organisational system when it came to tackling the situation caused by the COVID-19 pandemic, overburdening and triggering intense physical and emotional fatigue among the nurses interviewed (Perez-García et al., 2020). However, despite being overwhelmed by fear, fatigue, distress, and suffering, nursing professionals expressed a sense of ethical responsibility to tackle the situation and care for people as their professional duty, regardless of the stressors affecting them (Ohta et al., 2020). Nurses even expressed a sense of deep satisfaction as a result of helping others, feeling satisfied with their ability to carry out their work despite the difficult situation (Ruiz-Fernández et al., 2020).

Another theme found in the study was the impact of exposure to suffering on nurses. For those who were not morally prepared, this suffering had a significant impact, giving rise to anxiety, frustration, and sadness and impeding their ability to understand human responses from highly vulnerable people (Halcomb et al., 2020). This sustained contact with suffering is dangerous for professionals. It is not exclusive to the pandemic, however: it had been observed in previous years (Ruiz-Fernández et al., 2020) but was aggravated by the pandemic (Alharbi et al., 2020). If this situation continues over time, professionals may begin to perceive the work they are expected to undertake for the rest of their working lives as arduous and costly, a dead-end where some form of suffering will always be present (Morse, 2000).

This indicates the need for interventions to mitigate the impacts of inadequate management of nurses' own suffering and that of patients receiving care (Robles et al., 2020). It is also urgent for workers' suffering to be considered a priority issue by institutions and managers (Gismera et al., 2019; Gismera-Tierno et al., 2017).

5. Limitations and future lines

Despite the important results obtained, this study has several limitations. Firstly, more long-term studies on the impact of nurses' exposure to suffering on stress, exhaustion, and compassion fatigue are needed. Secondly, the restrictions imposed by the Spanish government made it impossible to conduct face-to-face interviews, which would allow more active listening and a greater rapport with participants. In principle, this could constitute a limitation, but it allowed the interviews to be conducted remotely during a period when mobility was restricted and enabled filming without face masks, as this could represent a major obstacle to capturing the nuances of non-verbal communication.

Recording the interviews in this way created a private environment that was prepared in advance with the interviewees. This method also allowed verbal and non-verbal communication to be taken into consideration in the transcripts (which is not possible with traditional voice recording) and to revisit them as many times as necessary to capture all the information. Thirdly, the majority of participants were women, but it goes without saying that the nursing profession is mainly exercised by women. In addition, the participants worked mainly at primary care facilities. Although this might seem to be a limitation, it can also be an enriching aspect, since, at the time of the study, COVID-19 patients were cared for and followed up at the community level. Finally, we cannot ignore social desirability bias and recall bias, whereby participants may have adjusted their responses to the needs of the study or failed to remember certain situations. However, the methodological rigour used in this study, together with the fact that it was conducted in the midst of the COVID-19 pandemic, made it possible to control for both types of bias.

With regard to future lines of research, it is important to explore the continuation and progression of the COVID-19 pandemic and its repercussions for healthcare professionals, who have played a key role in tackling the situation. Designing programmes or interventions to cultivate compassion could improve healthcare professionals' management of suffering, protecting nurses from compassion fatigue, helping to generate adequate levels of compassion satisfaction, and making their work more rewarding by allowing them to grow and develop a more holistic, compassionate vision of people and the world.

6. Conclusions and implications

This study has revealed the most important aspects of nurses' experiences of suffering during the pandemic, as well as the main causes and repercussions of this suffering. The findings demonstrate the immense emotional and psychological impact of the pandemic on the participants' professional and personal lives. They also show that healthcare professionals are inadequately prepared to manage their own suffering and that of their patients. Suffering people often display harsh, complex human responses, especially in situations of significant vulnerability. Excellent compassion skills are needed to identify these responses in a professional manner, perceive the needs expressed through them, and target these needs when delivering care.

Our findings have several implications for nursing. Firstly, they point to the need to develop specialised programmes for nursing professionals based on managing and addressing their own suffering and that of others by applying compassion and emotional intelligence to avoid repercussions such as powerlessness, frustration, and a desire to quit their jobs. Secondly, from the perspective of both ethics and corporate profitability, it is very important for institutions to approach suffering among their employees (in this case nursing professionals) as a priority issue.

CRediT authorship contribution statement

Declaration of competing interest

The authors have no conflicts of interest to declare.

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Ethical considerations

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