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Cross-cultural differences and similarities in nurses' experiences during the early stages of COVID-19 in Korea and the United States: A qualitative descriptive study

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**Title:** Cross-cultural differences and similarities in nurses' experiences during the early stages of COVID-19 in Korea and the United States: A qualitative descriptive study

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### Abstract

**Background:** At the onset of the COVID-19 pandemic, governmental responses varied worldwide, which resulted in healthcare professionals and organizations having different experiences. As threats of global infectious disease and disasters increase, it is important to examine the collective experiences of nurses to leverage support across international settings and systems and to tailor specific policies to their local nursing workforce.

**Objective:** To compare and contrast nurses' experiences working in hospitals at the onset of COVID-19 in South Korea and the United States

**Method:** This was a qualitative descriptive study. Nurses in South Korea and the United States were recruited through social media using snowball sampling between April and May 2020. Semi-structured telephone interviews were audio-recorded, transcribed, and translated as needed. The transcripts were analyzed thematically, and each theme was compared and synthesized using NVivo 12.

**Results:** A total of 43 nurses from South Korea ( $n = 21$ ) and the United States ( $n = 22$ ) participated in the study. The majority of the participants were female and working as staff nurses in both countries. The work settings were similar between the participants from two countries. However, the participants in South Korea provided less direct care to patients with COVID-19 compared to the participants in the United States. Despite cultural and infrastructure differences, the nurses shared similar experiences.

**Conclusion:** The overlapping similarities of nurses' experience highlight the need for national and global policies for a safe work environment and psychological well-being. The differences between the two countries also emphasize that specific policies and practice implications for the local contexts are needed in addition to global policies.

**What is already known**

- The COVID-19 pandemic has challenged healthcare professionals, including nurses, physically and mentally around the world.
- The long-term impacts from COVID-19 on the nursing workforce has already begun at individual, organizational, and national levels with increased burnout, turnover, and nurse shortages.

**What this paper adds**

- Despite the differences in national and cultural contexts, nurses share similarities in their experiences that support the need for global, institutional, national, and local policies to build, protect, and support the global nursing workforce.
- There are also specific cultural differences in nurses' experiences that could guide local policies and programs to support nurses.

## Introduction

With more than 621million confirmed cases and over 6.5 million lives lost worldwide (Ritchie et al., 2022), the coronavirus disease 2019 (COVID-19) pandemic has been the deadliest viral outbreak in over a hundred years. It also endangered the lives of nurses and other healthcare professionals due to a shortage of personal protective equipment and the novelty of the virus (Cohen & Rodgers, 2020). In addition, the relentless COVID-19 pandemic amid public discord over vaccines and basic safety protocols, such as distancing and masking, nurses and healthcare professionals have registered historic levels of personal and occupational fatigue and burnout around the world (Bhanja et al., 2021; Denning et al., 2021). Even though a degree of normalcy returned for people at large with the availability of vaccines and better treatments for COVID-19, the stress healthcare professionals face has not lessened (Falatah, 2021). In fact, there is an increasing concern for the long-term psychological and organizational consequences, such as burnout, psychological distress, and turnover among nurses and other healthcare professionals ( Falatah, 2021; Lavoie-Tremblay et al., 2022; Søvold et al., 2021).

Unfortunately, extreme events, such as COVID-19, are projected to become more frequent (Marani et al., 2021). A recent report in the Proceedings of the National Academy of Science showed that the probability of a pandemic with an impact similar to COVID-19 was about 2% in any year and growing, driven by factors such as population growth, changes in food systems, environmental degradation, and more frequent contact between humans and disease-harboring animals (Marani et al., 2021). Therefore, building and maintaining a global healthcare workforce, including nurses at the local and international settings, is more critical than ever before (Søvold et al., 2021).

Although each country has unique culture and systems, the globalization of the healthcare workforce and increased frequency of global events necessitates an analysis of the collective and shared experiences of nurses from diverse cultural contexts. Such investigation is indispensable for identifying the general patterns transcending cultures and can underscore institutional, local, and national policies that potentially guide nurses and nurse leaders to understand, prepare, and support the global nursing workforce. Nursing is the largest healthcare workforce that is often at the frontline for early response to disease outbreaks and pandemic surveillance. The first step to identify patterns is to explore the experiences of nurses from different cultural contexts. However, despite the prolific amount of published studies examining nurses' experiences during COVID-19, we could not locate any study that explored the experiences of nurses cross-culturally. Therefore, this study aimed to qualitatively compare and contrast nurses' experiences from two different cultural and organizational contexts working at the onset of COVID-19, specifically in South Korea (Korea) and the United States (US).

## **Methodology**

### **Study Design**

The study design was qualitative descriptive, which is a research methodology using everyday language to describe a phenomenon (Sandelowski, 2000). This methodology seeks to capture an accurate accounting of events and the meanings participants attributed to those events. It aims to generate data describing the who, what, and where of events or experiences (Sandelowski 2000). Thus, this study design is most appropriate for studies that require staying close to and describing an event or experience (Doyle et al., 2020).

## **Sample and Recruitment**

For initial recruitment, we posted the study information on social media platforms (Facebook, Twitter, and KaKao Story) between April and May 2020. In the US, the research team members posted the study information on their Twitter pages for their followers to share, whereas Kakao talk and Facebook were used in Korea. Interested nurses made initial contact with the research team by directly messaging on social media or sending an email to the address provided. Once the virtual connections were made, we confirmed their eligibility and scheduled individual semi-structured interviews with the lead author. In addition to direct recruitment through social media, we employed snowball sampling, in which we also asked the participants to identify and share the study information with other potential subjects. To participate, individuals were required to (a) be a currently registered nurse from the US or South Korea, (b) be employed in a hospital at the onset of COVID-19, (c) be able to speak either Korean or English, (d) be at least 18 years old, and (e) be able to provide verbal consent. Those who worked in other settings, such as outpatient clinics, were excluded.

## **Data Collection**

All data were collected via smartphone app or telephone. For the Korean participants, the lead author, who has a doctorate and previous qualitative research experience, used the smartphone function of KaKaoTalk, the most widely used communication app in Korea to conduct the semi-structured interviews. For the nurses located in the US, a landline phone was used by the lead author. The phone interviews occurred in April and May 2020, lasted between 45 to 90 minutes (averaging 62 minutes), and were audio-recorded. The interviewer (the lead author) spoke both Korean and English and took reflective notes following each session. No additional interviews were conducted once the team concluded that information redundancy



(saturation) had been reached with no new themes emerging. The researchers had no previous relationship with any of the participants. The interview guide included open-ended questions, such as “What are some of the concerns you have about COVID-19?” or “Tell us about your experience working as a nurse during COVID-19” and basic work-specific queries regarding occupational setting and nursing experience (Supplement A). Participants received a \$50 digital gift card as compensation for their time.

### **Data Analysis**

Once the interviews were completed, recordings were transcribed verbatim. Two native speakers (JJ, SYP) translated the Korean interviews. The transcripts were analyzed through aggregated thematic context analysis, a well-established method for qualitative data analysis among two separate groups (Braun & Clarke, 2006). Data analysis took place in four steps. First, two research team members read the interview transcripts to get a general overview of the content and then uploaded the transcripts on the NVivo 12.0 software to create a codebook of emerging themes. Next, three team members coded the transcripts individually, then met to compare and finalize the themes. Lastly, the research team developed a table to best reflect the themes, subthemes, and supporting quotes.

Rigor and trustworthiness were achieved through the following procedures: (1) member checking, (2) self-reflection, and (3) audit trail. For member checking, participants were asked to clarify their statements during the interviews, and they were also asked to review the codification of interview statements after each interview. The interviewer (lead author) also self-reflected on their position as a female nurse and nurse researcher with Korean background living in the US while capturing participants’ statements throughout the interview process. An audit trail was also maintained to preserve the transparency of each step in the analysis.

## **Ethical Considerations**

The Institutional Review Board of the University of Michigan (HUM00178701) exempted this study. All participants were informed of the study's objectives, interview methods, and data-storage protocols before data collection. Before each interview, informed consent was obtained verbally and recorded. During the interviewing, we also did not ask any identifiable information such as their employer's name or other potentially sensitive information. The study was conducted in accordance with the principles of the Declaration of Helsinki.

## **Findings**

### **Participant Characteristics**

A total of 43 nurses, 21 from Korea and 22 from the US, working in hospital settings participated (Table 1). The majority of the participants were female (83.4%) and working as staff nurses (90.7%) in both countries. The average nursing experience for nurses in Korea was 8.9 years (Standard Deviation [SD] 3.5), whereas it was 4.9 years (SD 8.0) for the nurses in the US. Korean nurses resided and worked in Seoul, the capital of South Korea, or its surrounding suburbs, and the US nurses lived and worked in suburban and urban locations across nine states (Connecticut, Illinois, Massachusetts, Minnesota, New Mexico, New York, North Carolina, Oregon, and Washington). Lastly, only 14.3% of nurses in Korea provided direct care to patients with COVID-19 compared to all US nurses.

### **Six Thematic Findings**

We have identified six themes (four similarities and two differences) that emerged between the two groups, as listed in Table 2. The first four themes were similarities: (1) fear of the virus, (2) worsening workload and staffing shortage, (3) feeling disposable, and (4) renewed purpose. The differences were in (5) preparedness and (6) public responses.

**Fear of the Virus.** Fear of the virus was the most common theme expressed by all nurses from both countries. Nurses witnessed the devastation of the virus firsthand, were shaken by the chaos at the onset, and feared that they might be exposed to the COVID-19 virus and unwittingly spread it to patients, co-workers, family, or community members. Consequently, they practiced strict social isolation, self-quarantined, exercised added vigilance with respect to their hospital scrubs and personal hygiene, and insisted on physical distancing, even in their own homes, by sleeping in a separate room or temporary housing provided by the hospital. One of the Korean nurses stated: “How fast and quickly the coronavirus is spreading is really scary (K11).” This sentiment of fear was also echoed by a US nurse “Biggest fear I had was getting the virus and then spreading to my co-workers or family (US 6)”

**Increased workload and persistent staffing shortage.** Korean and US nurses both emphasized assuming the burdens of increased workload and chronic understaffing during COVID-19. This absorption of extra responsibilities occurred at the same time as nurses were already accommodating an influx of patients and adapting to rapid and recurring revisions to new practice policies (e.g., infection control, treatment plans) while struggling with fluctuations in staffing. Korean nurses, for example, became responsible for informing patients of COVID-19 procedures and for collecting payment information, in addition to their existing responsibilities of patient care. Similarly, US nurses took on tasks previously carried out by ancillary staff, such as cleaning. Even with the extra responsibilities, staffing levels remained inconsistent and inadequate, with a nurse-to-patient ratio that either stayed the same or increased. One of the Korean nurses explained the reason for the persistent staffing shortage. “Hospitals don’t have any reasons to hire more nurses. The hardest thing for nurses is not having enough staff but for hospitals, things still run, and patients still come. So why should they hire more nurses? (K5).”

This sentiment is echoed by the US nurses, “They [their hospital] were like, Let's just make them do it, let's just make nurses do it themselves. Yeah, those things that I felt very disrespected by it (US6).”

**Feeling disposable.** In addition to the increased workload with a persistent staffing shortage, nurses also collectively voiced feeling as though they were disposable in the eyes of their organizations. Nurses believed that the understaffing and shortage of nurses was a function of the hospitals' valuing budgetary concerns above the well-being of the nurses. As one Korean nurse summarized, “We are an expense... Hiring more nurses hurts the hospital financially (K5).” Nurses from both countries repeatedly stressed that they did not feel that they had a voice in making decisions that affected their health and well-being, thus rendering them both “invisible” and “mute” in their organizations. One US nurse even portrayed being frontline nurses as akin to the experience of working on the assembly line of a large factory, where, should something happen to an employee. They would simply be replaced without repercussion to the employer. Korean nurses perceived themselves as disposable because they became the scapegoat for both patients and the healthcare system itself. Although some patients expressed gratitude to nurses, more often than not, nurses bore the brunt of patients' anger and frustration over being quarantined or needing to be tested frequently for COVID-19, while the nurses were performing their duties and communicating information or being facilitators of protocols and policies put in place by the organizations. The US nurses also emphasized the dissonance between what their organizations announced publicly and what they were doing privately. In particular, US nurses explained how their employers praised them in campaigns and public-relation endeavors yet offered little in the way of leadership—even leaving them understaffed and failing to provide personal protective equipment or meet other basic needs in a workplace

fraught with profound risk. In this way, organizations were able to maintain the appearance of supporting frontline workers even as the reality was very different. One of the US nurses summarized this sentiment as follows, “Hospitals typically just blamed the nurses for so many things, but we are one of the most vital piece now. Something has to happen for us staff, because we are the ones that really are on the ground. (US4).”

**Renewed Sense of Purpose.** Nonetheless, nurses from both countries also reported feeling a heightened sense of meaning and a renewed purpose in their work. Nurses all shared a similar sentiment that the crisis underscored how essential their work was and the significance of the training and education that had prepared them to respond to such an extraordinary set of conditions. These nurses felt proud of providing care to COVID-19 patients and allowed themselves the internal affirmation of importance and achievement that, too often, was not expressed in any meaningful way by their organizations. Korean nurses frequently expressed a sense of collective professional and communal responsibility and duty to their colleagues, patients, and society. One of the Korean nurses summarized this duty, “It’s the power of solidarity. When the country is in an emergency, we come together, all the medical teams, the citizens of South Korea... we all come together in solidarity. And that’s how we get through it. This is what I can do. (K8)” In particular, these nurses felt obliged to perform their duties alongside their colleagues, especially during critical needs. US nurses also expressed their renewed sense of purpose in terms of a rekindled professional pride. For example, the US nurses felt that COVID-19 provided an opportunity to figure out the next steps in their careers, felt proud to find that purpose, and were happy to be recognized for the work they felt had been taken for granted before COVID-19. As a US nurse stated, “At the end, it just makes you grow. I learned something new. I got smarter, and I did it (US8).”

**Preparedness: *Past epidemic vs. New territory.*** One of the significant differences between Korean and US nurses' experiences stemmed from the respiratory outbreaks of Middle East Respiratory Syndrome (MERS) in 2015. The majority of Korean nurses recalled their experiences from the Middle East Respiratory Syndrome outbreak, and they felt that, to some degree, the public health system, hospitals, and staff were prepared with adequate resources, supplies, and training. As one Korean nurse explained, "We've been through the MERS. When [it] happened, it was chaos. But all the things we developed since are helping now. When Middle East Respiratory Syndrome happened, it was a really big mess and very stressful. We never had anything like that before so no one even knew how to handle anything. So compared to that, we are much better now with a designated team for COVID (K9)."

Compared to Korean nurses, who credited their prior experiences for encouraging the strict "control" mindset at the onset of the pandemic and faster and more efficient responses from the government and organizations, US nurses felt caught off guard. Only two of the 22 US nurses who participated in this study received specialized training in contagious infectious disease practices. Even these two nurses felt ill prepared while responding to the COVID-19 virus because their hospitals, despite being designated for such treatment, had not activated their special infectious units prior to the COVID-19 pandemic. Furthermore, some nurses had been thrust into new clinical situations with little or no training. For example, non-Intensive Care Unit nurses were obliged to handle ventilated patients with little or no orientation to Intensive Care Unit to accommodate the ballooning number of patients on ventilators and those requiring Intensive Care Unit level care.

**Public responses: *Public stigma vs. Fleeting heroism.*** Lastly, nurses' experiences with the public's responses at the onset of COVID-19 also differed. Korean nurses frequently stressed

the public stigma attached to being frontline nurses. Specifically, one participant mentioned how their children's daycare provider asked them to find care elsewhere because other parents were concerned about the dangers of their job. Another Korean nurse reported being harassed in the following statement, "Some of my colleagues quit their jobs because their families were getting harassed because they were nurses. And I can understand that completely (K13)." Several Korean nurses mentioned that their employers required them to sign a pledge restricting travel, attending events, or even going outside other than for essential purposes. As another Korean nurse described, "I can't go anywhere because I'm afraid. If something happens, then they will trace it and blame me (K10)." All the Korean nurse participants reported being less concerned about contracting COVID-19 and were, instead, more worried about enduring the social stigma. In contrast, the US nurses did not mention having stigmatized experiences and instead recalled more positive responses from the public, including the 7 pm cheers that occurred collectively around the country. The US nurses observed increased public support, including encouraging words, being called "heroes," and getting food delivered to their units. Unfortunately, all US nurses also predicted that such support would be fleeting when the initial wave of goodwill subsided.

### **Discussion**

This study compared and contrasted the similarities and differences in nurses' experiences living and working in two different cultural and organizational contexts at the onset of COVID-19. Located on opposite sides of the world, nurses from Korea and the US each struggled with similar challenges and triumphs of working through their fear, keeping up with both an increased workload and constant changes, all the while feeling both disposable and a renewed sense of

purpose in their work. There were also contextual differences in nurses' experiences, such as preparedness based on their experiences and the responses from the public.

Korea and the US were chosen for this cultural comparison study as these two countries had vastly different local and federal government responses (Solano et al., 2020). Korea discovered its first case on January 20, 2020, and quickly registered the most cases outside of China. However, the Korean government initially curbed the number of cases through a swift public health response involving contamination and mitigation strategies, mask mandates, rigorous contact tracing, diagnostic tests, strict lockdowns, and travel restrictions (Solano et al., 2020). As a result, Korea experienced fewer confirmed cases and achieved a lower mortality rate compared to other countries. The US, by contrast, discovered its first case on January 21, 2020 but did not declare a public health emergency until February 3, 2020, three days after the World Health Organization had already declared a global health emergency. The public health response in the US was more delayed and fragmented than it was in Korea due to, among other things, the federal system of government that accords considerable authority to individual states when regulating the health, safety, and welfare of their citizens.

Even though many studies on nurses' experiences during COVID-19 have been published, we could not locate any cross-cultural studies. Nonetheless, based on the previous literature, nurses shared more similarities than differences in their experiences and job stressors despite the different cultural and country-specific professional roles and responsibilities (Lambert et al., 2004). We also found that nurses shared many similarities, such as fear, increased workload, and renewed purpose, despite the different respective cultural contexts. In particular, nurses from both countries expressed feeling disposable in the eyes of their organizations, as if they could (and would) be easily replaced should something happen to them.



This perceived disposability persisted even with outward displays of support and appreciation from their organizations, the media, and the public. For example, a qualitative study of critical care nurses in the US found that nurses felt disillusioned and betrayed by their organizations, leading them to consider leaving their position or even quitting the profession (Gordon et al., 2021). The COVID-19 pandemic pushed nurses to the emotional brink and revealed something that nurses have felt for decades — nursing work feels and is essentially invisible and lacking in status (Mabe, 2008; Nelson, 2011)). Unpacking the persistent invisibility of nursing is complex. Previous researchers have suggested that the gender-based origin of nursing (D'Antonio et al., 2010), the image portrayed by the nursing profession (Mabet, 2008; Nelson, 2011), and the caring and emotional aspects of nursing work contribute to the invisibility of nursing (ten Hoeve et al., 2014). In our study, however, nurses focused on the economic invisibility. For example, nursing care and services are economically invisible as fixed costs embedded as a line-item charge for room and board regardless of the degree of care that a patient either requires or receives (Gordon, 2005; Lasater, 2014). This lack of actual, meaningful economic presence prefigures nurses simply as a part of a hospital infrastructure —merely another "expense" rather than as an organizational asset (Lasater, 2014).

In addition to these shared experiences, there were also significant differences—distinctions likely due to their respective cultural contexts. While US nurses rarely mentioned the notion of stigma, Korean nurses highlighted stigma related to their job and societal pressures and expectations extensively. Stigma is a personal experience of discrimination marked by exclusion, rejection, criticism, or devaluation based on perceived social characteristics that distinguish an individual from other members of society (Ramaci et al., 2020). It also has been associated with increased burnout, stress, depression, and anxiety (Hennein et al., 2021; Kim & Yang, 2021).

Research has demonstrated that stigma against healthcare workers during infectious disease outbreaks is common. There have been numerous reports of healthcare workers of being labeled, set apart, isolated, deprived of status, and subject to discrimination owing to the stigma of COVID-19 in several countries, including the US (Dye et al., 2020; Lee & Lee, 2020; Ramaci et al., 2020). In a large, multi-country, mixed-method study, healthcare workers experienced significant stigma and bullying related to COVID-19, especially at the intersection of racism and violence (Dye et al., 2020). Meanwhile, a qualitative study of Korean nurses felt they were being treated like a virus and that outside of work, those around them were relieved to have them isolated (Lee & Lee, 2020). Even though nurses in North America have been less likely to experience stigma on a personal level compared to their counterparts in Asia (Dye et al., 2020), healthcare workers still perceive that others prefer to avoid them out of fear that they might be carrying the virus (Taylor et al., 2020).

The findings from this study have important implications for research, policy, and practice. First, organizations and the healthcare system must ensure nurses' physical and psychological safety. For physical safety, nurses require adequate staffing and resources to perform their duties and deliver quality care. Global standardization of a minimum nurse-to-patient ratio should be established. There is a large body of evidence from decades of research demonstrating the importance of safe staffing ratios for both patient care and the retention of nurses (Driscoll et al., 2018). Furthermore, nurses must be free of any form of harassment or stigmatization in or around the workplace. More than 30 states in the US already have criminal statutes specifically designating assaults on nurses as a felony offense (Occupational Safety and Health Administration [OSHA], 2015). However, only two states, Utah and Wisconsin, currently expanded 'assaults' to include harassment and threat of violence. In recent months, the number

of anti-vaccine protestors congregating outside hospitals and verbally attacking nurses and other healthcare providers has increased. While limited and isolated, such behavior can further erode the morale of nurses who are already exhausted and overburdened. Although the legal duty and responsibilities of employers set by the law stated in the Occupational Safety and Health Act of 1970 are limited to furnishing places of employment free from recognized hazards (OSHA, 1970), a proactive approach centered on the psychological safety of nurses would benefit employers in the end. No staffing ratios or organizational characteristics can entirely repulse workplace stress or social stigma, especially during a generational crisis. However, organizations evincing greater unity between words and deeds—matching policies and culture with actions and practices—is a necessary place to start.

Second, the long-term organizational and individual consequences of COVID-19 on nurses and other healthcare professionals must continue to be documented and investigated. Since 2020, the number of research studies on nurses' well-being and health, particularly mental health, skyrocketed, and professional organizations, such as the National Academy of Medicine, have dedicated efforts to reversing trends in clinician burnout. Nonetheless, much of the role and impacts from both the negative and positive experiences during COVID-19 on nurses' psychologic and physiologic health, as well as on their organizations and society, will require further examination.

### **Limitations**

This study has several limitations. First, the researchers recruited nurses using snowball sampling, presenting a degree of self-selection bias, which increases the potential of those with different perspectives or experiences being missed. Second, we included only nurses working in hospitals at the onset of COVID-19. Nurses working in other settings have also been greatly

affected, and it is possible that by excluding non-hospital nurses, our study failed to capture other nuances of their experiences. Lastly, the nurses in our samples had slightly different lengths of tenure. This was partially due to the different modes of entry to practice. In the US, some nurses enter nursing as a second career, whereas there is no such option for a second career entry in Korea. However, we did not explore the differences in the education system, as it was not the goal of the study. Nonetheless, the possible differences in their work tenure could correspond to differences in their experiences with COVID-19.

### **Conclusion**

The COVID-19 pandemic has challenged every healthcare system and healthcare professional globally. The nurses in our study, hailing from different parts of the world, have experienced many of the same struggles and triumphs—fear of the virus, feeling disposable due to worsening workload and staffing shortage, and renewed purpose—despite their unique societal, cultural, and organizational differences. However, there were also distinct differences in preparedness and experiences with the public. Our analysis provides evidence that several key aspects of organizational and system-level considerations, such as adequate staffing and the development of a supportive workplace culture, are applicable globally. At the same time, there is also the need to consider local specific contexts, such as policies for physical and mental protection.

**Conflicts of interest:** none

**Declaration of interests**

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

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Table 1. Participant Characteristics (N= 43)

	<b>South Korea</b>	<b>The U.S.</b>
	<b>(n = 21)</b>	<b>(n = 22)</b>
<b>Sex, n (%)</b>		
Female	18 (90.5)	18 (81.2)
Male	3 (9.5)	4 (18.8)
<b>Average years of nursing experiences, years (SD)</b>	8.9 (3.5)	4.8 (8.0)
<b>Direct Contact with patients with COVID-19, n (%)</b>	3 (14.3)	22 (100)
<b>Nursing Position, n (%)</b>		
Staff Nurses	20 (95.2)	19 (86.4)
Nurse Manager/Charge Nurse	1 (4.8)	3 (15.6)
<b>Nursing Units, n (%)</b>		
Emergency Rooms	6 (28.6)	2 (9.1)
Intensive Care Units	4 (19.0)	9 (40.9)
Medical/Surgical/Stepdown	6 (28.6)	8 (36.4)
Oncology	3 (14.3)	2 (9.1)
Others	2 (9.5)	1 (4.5)

Note: *SD* = Standard deviation

Table 2. Summary of similarities and differences in thematic findings

<b>Similarities</b>	<b>Differences</b>
1. Fear of the virus	5. Preparedness (Past epidemic vs. New territory)
2. Worsening workload and staffing shortage	6. Public responses (Public stigma vs. Fleeting heroism)
3. Feeling disposable	
4. Renewed purpose	

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