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Exploring the Causes and Effects of Nurses Suffering in the Healthcare System

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ABSTRACT

Chronic and sustained suffering among nurses working in the healthcare system is common. This has implications for the whole healthcare system, with potential negative effects on patient experience and safety. In addition to professional impact, suffering is also detrimental to personal well-being. Understanding why nurses suffer and the impact of this form of stress on them is necessary if resources for psychological therapies are to be used effectively to counteract it. This, however, is a neglected area of inquiry, with most research in this field investigating levels and causes of burnout. This study encompasses quantitative and qualitative evaluations of 58 acute hospital nurses' accord, testing relationships between workplace stress and ward climate with outcome measures such as depression, anxiety, and stress. Results were triangulated with data from in-depth semi-structured interviews to establish a comprehensive understanding.

KEYWORDS: healthcare, nursing, therapies.

1. Introduction

Chronic and sustained suffering among nurses working in the healthcare system is common. This has implications for the whole healthcare system, with potential negative effects on patient experience and safety. In addition to professional impact, suffering is also detrimental to personal well-being. Understanding why nurses suffer

and the impact of this form of stress on them is necessary if resources for psychological therapies are to be used effectively to counteract it. This, however, is a neglected area of inquiry, with most research in this field investigating levels and causes of burnout. This study encompasses quantitative and qualitative evaluations of 58 acute hospital nurses' accord, testing relationships between workplace stress and ward climate with outcome measures such as depression, anxiety, and stress. Results were triangulated with data from in-depth semi-structured interviews to establish a comprehensive understanding.

This study investigates the causes of nurses' suffering driven by stress and the effects of this on their mental well-being. Prevalence rates and causes of nurses' stress have been investigated in myriad studies. In contrast, the impact of the experience on the nurses themselves, 'outcome evidence', has been researched far less. An exploration of the effects of enduring suffering on nurse well-being, however, may provide a potential impetus for intervention. Research describing the consequences of 'burnout' demonstrates that chronic and relentless exposure to stress can result in poor personal and professional function, with symptoms such as apathy, negativism, and a lack of enthusiasm among those who typically 'cheerlead' stressed workers. This phenomenon, however, becomes blurred with anxiety and depressive symptoms and has been the subject of less research. The effects of burnout therefore may not capture the personal impact of chronic occupational suffering. The present study seeks to provide information about the psychological consequences of such stress. It is expected to fill a current lacuna, using outcome evidence of this suffering population to inform strategies to counteract it.

1.1. Background and Significance

The resurgence of nurses' suffering in the contemporary healthcare system is a by-product of historical and political systematic colonization. Nursing continues to struggle as a female-dominated profession to assert itself in a patriarchal, sexist, and hierarchical society, as well as a male-dominated healthcare sector. High workplace demands on nurses contribute to high staff turnover, low tolerance of the healthcare system, poor physical and employee health, and reduced patient satisfaction, which in turn can have a negative impact on the health of the healthcare system more broadly. In order to address the broader systemic workplace suffering of nurses, factors perpetuating such adversities need to be explored. At present, much of the research on the topic is either substantially descriptive or it was narrow and symptomatic.

A state of suffering is a result of a complex interplay of a range of factors: cultural, social, economic, and political factors, which in turn inform and shape the workplace environment as well as the individual perspective of the world and their place within it. The commitment of nurses to their work and the healthcare consumers, within a historical, institutionalized and societal oppression context may result in continued workplace bullying, psychological harm, and poor general health.

1.2. Purpose of the Study

Nursing has increasingly been recognized and documented as suffering, which in Western cultures denotes a heavy burden leading to grief and distress. Until now,

nurses' suffering has been documented from various theoretical perspectives and for many different reasons, yet research that encompasses the phenomenon is scarce. Through empirical data on the phenomenon of suffering in nursing, our analysis may render assistance to other stakeholders operating within the healthcare system. The purpose of the study is to develop the empirical knowledge of the multifaceted concept of the phenomenon of nurses' suffering in healthcare.

Research questions: The study is guided by the following questions: 1. What do nurses themselves offer as an explanation of suffering in nursing for themselves and their co-workers? 2. What further cause-and-effect relationships can be identified in this narrative? Literature has documented that nurses suffer, and various theoretical explanations are suggested. To provide the best practice and policy support to each stakeholder, it is important to evaluate the theoretical contributions in relation to empirical insight. There is a great need in today's society for empirical knowledge of suffering from the perspective of the individual human being. Practice improvements can only be achieved through an extended understanding of suffering as evaluated and expressed by nurses themselves. Thus, there is a need to transform the knowledge base from mainly theoretical contributions to empirical accounts.

1.3. Scope and Limitations

Scope. Because of the aims expressed in the objectives and questions, this research focuses on examining one particular aspect of the experiences of practicing nurses. We are interested in identifying core attributes of "nurses suffering" across a range of work settings, so potential interviewees for the research were identified across the healthcare sector. We believe the scope of the research is such that it is possible to find nurses who are suffering, or who have ceased to nurse because of suffering, in every country. We purposefully aimed to locate interviewees involved in a variety of settings to ensure that the accounts we collected were as wide-ranging as possible, recognizing the extent of the practice and role of nursing across different healthcare locales. (Schroeder et al.2020)(Saab et al., 2021)(Guttormson et al.2022)

So, while we welcome respondents from any nurse-related field of practice, it should be noted that we did not ask alternatively trained non-nurses who are engaged in care-related work for their view of nurses suffering, nor did we ask physicians, social workers, or other health professionals for their views. While we presume that their views of nurses suffering may be informed by knowledge developed through working with or hearing about nurses' experiences, we did not elicit the unique perspective of those who are not members of unions for nurses only or the nursing profession. Nurses are not a homogeneous group, and one limitation of our sampling and data collection is the relative population surveyed. We do not, for example, meet nurses who work in offices or as nurse recruiters, who teach primarily at schools of business, or work as research nurses. We do, with a few exceptions, meet nurses who are providing direct care/clinical education who define their primary/sole profession to be that of registered nurse. Similarly, male nurses are underrepresented in our population of nurses striving to deliver effective, compassionate, moral practice. Finally, we seek to include interviews with nurses who are working outside an acute-care environment, who are not representing the role of the majority of nurses.

Limitations. At the outset, we acknowledge some expected weaknesses in this kind of qualitative study. Learning how nurses have experienced suffering is not a traditional area of inquiry. As has been identified, many nurses have been working around 30 years, but suffered for too long to start comparing different job situations in our society, which was not sufficiently researched. A degree of recall bias may also have influenced nurses' accounts of suffering. Finally, the views of the nurses will not be representative of the 2.8 million nurses in the United States, or the additional million in combined healthcare systems around the world, all of whom are possible advocates for change.

2. Understanding Nurses' Suffering

This paper aims to explore the causes that lead to nurses suffering in healthcare systems and the effects these have on nurses, patients, and larger communities. An initial step is understanding nurses' suffering itself. Two useful places to start are defining suffering and establishing what we mean when we refer to nurses. 'Suffering' is often defined by the experiencer's internal, i.e., individual and personal context, but invites us to understand that suffering is equally an external, public phenomenon. This differentiation stresses the perception of suffering as well, an important point when discussing support, services, and interventions for alleviating suffering. The same overarching analysis of nurses is beneficial, though a professional context is of most concern here.

Sharing the dual nature of individuals in a system or structure, this suggests small as well as radical interpretations of nurses' being and suffering. The distinction can refer to their nature as individual operators in the healthcare system, but can also refer to nurses being and succumbing to suffering rather than merely feeling it. Nurses' suffering can be emotional as well as physical. It can arise from a nurse herself—a constellation of fatigue, bodily pain, and mental distress. It can also be experienced through the nurse, including moral injury or moral distress from ethical dilemmas rooted in difficult, unfair, or unjust staffing, investment, and equipment decisions (or lack thereof). These overlapping definitions and interpretations of 'suffering' color a healthcare system as an intensely relational experience.

The experiences range from isolated professional opportunities to cross-systemic issues, and avenues of exploration can both uncover how nurses' own well-being is part of a larger social movement and attend to nurses being the patients in these systems. The multifaceted and amorphous characteristics of patients' and communities' suffering are also consistent with this proposal. Shared issues, incidents, and people cause suffering, part of why social justice and quality and safety discourses can likewise pertain to nurses.

2.1. Definition and Types of Suffering

Introduction Designing any facet of care requires familiarity with the life world, including the beliefs and values of those being cared for; conversely, it also requires an understanding of individual and collective suffering. Defining suffering What is understood as 'suffering' by an individual might not be interpreted similarly by others. The master nurse in the hospice stated, 'there are different types of suffering,

like personal suffering, which is only something people can really do to themselves, and then there's social suffering, which is what those people do to others in their lives and their communities.' Psychological and social dimensions are termed 'inward suffering' and consist of how individuals feel and interpret their situation; therefore, while one individual may 'suffer' by not getting the job that they wanted, which they were promised, another individual may feel 'let down'. In addition to this is the 'outward social suffering', when, from an external stance, distress is palpable, yet insight into what causes the distress is not always straightforward, causing challenges in the provision of non-invasive support. It is suggested that those who encounter serious traumatic experiences may comprise the highest proportion of people who describe their experience as actual 'suffering', be that in relation to their own experience, or witnessing other sufferers. From a care practice perspective, social suffering is often found to be the manifestation of psychological suffering in everyday social practice. In healthcare, it is the outward social suffering that nurses are witness to: 'the nurses working with those on the end are often seen to be suffering too.' In summary, there is a suggestion that suffering can be classified into three main types: experiencing a life-limiting condition, social suffering which includes people who witness the person suffering, and personal suffering. It is these issues that result in our need to provide spiritual care as well as resultant 'suffering', that we present to the person suffering in order to get our caring roles across and also our care so that we can suggest future interventions. Suffering therefore occurs when patients feel that their very person is unworthy of being called a 'self', and of being given their prior honesty, care, and social greetings. In healthcare, nurses are at the forefront and can themselves suffer given the direct responsibility in a care role. For the purpose of this paper, focus will be upon suffering in the healthcare system.

2.2. Factors Contributing to Nurses' Suffering

The literature identifies numerous factors contributing to nurses' suffering. At the systemic level, inadequate staffing along with patient acuity levels and patient-to-nurse ratios influence the amount of physical and emotional resources needed to manage patient care alongside documentation requirements. Lack of administrative support contributes to the emotional stress experienced by nurses. An atmosphere of "factory mentality," wherein employees are seen as a cog in the wheel, influences nursing morale. Additionally, nurses' use of socialization and relationships in the workplace for health-promoting coping mechanisms may be a double-edged sword, as detrimental relationships can lead to more stress. A number of cultural expectations and pressures contribute to nurse suffering in relation to society as a whole. Nurse practitioners and nurse medical residents' health is also impacted by today's society. Nurses serving a dual role as both employees and clients may add new factors of workload and staff burden. Clinical sites with poor working conditions may be passed over, thereby increasing inequality in the distribution of clinical sites. Lack of support in society may include pre-licensure education and society's conception of nursing.

There are many sources of financial stress, including nurses' own educational debt and the debt of nurses' children. In addition, many nurses with children are single mothers. As a result, these mothers experience conflicts between their job and their

children, resulting in burnout. Work schedules may interfere with nurses' ability to spend time with their family when the family is available. Resources are seen as systems that are increasingly part of health services and a source of professional illness. Nurses report having difficulty obtaining needed resources, such as necessary equipment and supplies, assistance from and with their nursing colleagues, etc., and will be unable to provide appropriate care. Direct effects include mental distress, intention to leave the organization, poor psychological health, poor physical health, feelings of irritability and unworthiness, high moral distress, emotional and physical exhaustion, lack of morale, and lower job satisfaction. Indirect effects include nurse turnover, ineffective communication, staff conflict, negative nurse-physician relationships, decreased nurse empathy, and ultimately low patient satisfaction.

3. Impact of Nurses' Suffering on Healthcare

The formal and informal rules that govern our healthcare institutions have to conform to the individuals who must put them into practice and to the values that those institutions want to represent. Creating, nurturing, and political role modeling of a values-based healthcare system are our collective responsibility. By focusing only on the impact of working practices on the psychological health of nursing staff, we set them aside from the well-being of the health service. The health, welfare, and in particular the happiness of the people who work in that system do not become an end in themselves; rather, they only become a concern when they start to present a threat to the health service in some form. The now extensive body of research makes it increasingly difficult to sustain the argument that a set of health professionals and administrative staff who suffer from stress, depression, and burnout are able to deliver consistently high standards of patient care.

The quality of staff-patient interactions is fundamental to high-quality, safe healthcare. Where allegations of inadequate care have been identified in several reports, they have often been linked to staff and in particular to nursing. Nurses are responsible for the majority of the hands-on care. To execute direct care, nurses perform assessments, observations, and routine interventions. In the context where staffing is adequate, observations of practice suggest that nurses are in some way fundamental to the system. The delivery of compassionate, attentive nursing care is therefore affected by the work situations of the nurse. There is some limited evidence suggesting that nurses who display high levels of emotional labor have poorer physical health outcomes. This would suggest that nurses who are compassionate are at risk of developing poorer health outcomes.

3.1. Quality of Patient Care

Nurses' suffering has been traditionally linked to the quality of care provided to patients. When nurses are burnt out and emotionally exhausted, their work is negatively influenced. Nurses have been identified as providers of care and patient advocates. As a result, if they are not well and patients' well-being is at the heart of their work, nurses may not concentrate on optimizing the quality of care. This point was highlighted by a number of the nurses in the interviews that were conducted. Suffering affects nursing practice. For example, it exposes nurses to ethical

dilemmas that can be impediments to developing a course of action in the course of their profession. This suffering has implications for the standard of health care as a whole. A case study pointed to a nurse trying to control her suffering 'but the power of [her patient's] suffering informed [her] practice ... ultimately disintegrating any desired divisions between self and the other – the nurse and her patient in this example.' This was echoed in the interviews, as one nurse said: 'If I've got upset about something, I think it would have to have an effect ... no one wants to be a robot.' The comments were similar throughout the interviews. Further, the 'breakdown of professional boundaries between patient and nurse ... can have ethical implications for the care the service user receives.' Mistreatment and lack of compassion can flow down the line of nursing care too. It was noted that 'in certain circumstances a nurse may be incapable of providing a service user with the appropriate high-quality care, time or resources available, simply because of the personal feelings of distress which have been engendered.' Also, nurses may be unable to physically provide care because of the tears and the 'shaking' due to their level of upset. This meant a nurse's absence would continue beyond breaks, as they are either taken to a 'secure area,' if they are upset, or to a hospital if they are physically unwell. These disadvantages affect both the health outcomes of the patient and the revenue of the health service provider. Thus, in order to address these systematic failures, the question of why nursing's well-being is not tied to patients' joy has been raised. Many other theorists have similarly advocated for systemic reform and the realignment of patient and worker needs to produce cost-effective and prosperous healthcare. (Rosa et al.2022)(Linton & Koonmen, 2020)(Todaro-Franceschi, 2024)

3.2. Nurses' Mental and Physical Health

Mental and physical health of nurses are interconnected. From the reviewed literature, it was clear that a significant amount of research has been conducted detailing that stress, anxiety, and depression may significantly reduce nurses' quality of life and job satisfaction levels due to workplace challenges, as these are common places in which they work. The main workplace challenges for nurses occur mainly due to a large number of patients with untreatable complications. Interviews showed that nurses suffer from anxiety, stress, and job dissatisfaction on a daily basis. The amount of suffering experienced by nurses is of great concern for their long-term health outcomes. Beyond physical issues brought about by job strains, nurses' offerings of self-care are reported to be generally inefficient. Necessary breaks and time that nurses need to eat, hydrate, and rest are often interrupted. In some cases, this can pose a safety risk to the care they provide.

The connection between mental and physical capability is supported by the biopsychosocial model. That is, it stands for counseling about how mental functioning can interfere with various areas, strongly affecting various conditions—in this case, job performance and quality of contributions to the workplace. In summary, the severe negative effects of job strain and suffering are reported. Nurses report physical health ailments due to job strain in the short term, and long-term effects can lead to mental health issues of depression or anxiety. The thorough analyses of the workplace and the various effects of job challenges that nurses report

show that their well-being is a large and interconnected issue. Although the effects of mental health may be prevented or treated with interventions that change nursing or workplace strategies, there is very little support within the workplace for the mental health of nurses. As such, it is easier to help nurses remain in a state of mental health. People feel a strong need to care for and help others (emotional exhaustion). Hence, if a nurse feels inadequate toward patients, the feeling of guilt or inadequacy often prevails. Support strategies and policies that were created within hospital environments focused on the reduction of mental health issues may be much more effective if a nursing workforce that has a high rate of mental health care, in the early years, is assisted.

4. Addressing Nurses' Suffering

Many strategies and interventions have been implemented to address suffering among nurses. Organizational support systems are widespread within healthcare and include employee assistance programs, person-centered approaches, occupational health services, staff support groups, and 24/7 telephone support lines. Running healthcare workers' support organizations has also been suggested so that they are maintained by people who understand suffering from their own experience. The possibility of recovery can sometimes be used to restore individual hope and optimism, reassuring healthcare workers they can "get better" and remain in the workforce, suggesting that some are "non-pathologizing" and potential suicide-enabling interventions. Different forms of debriefing intervention have also been proposed. These have usually involved individual or more generic group discussions where healthcare workers ventilate problems and learn about stress, even though this has been critiqued because people who suffer know about stress and trauma very well.

A number of problems and strengths have been identified with these strategies and interventions. In general, they are aimed at providing immediate reactive empathic psychosocial support to alleviate acute distress, and their success relies frequently on the approach that produces a subjective assessment of the victims' satisfaction expressed as happiness with the help received. Not everyone is in favor of these approaches, suggesting that returning to debriefing may unwittingly provide tacit organizational support for the reductionist concept of PTSD, which has caused so much harm in the field of psychological trauma and stress. More effective solutions need to be found at systemic and holistic levels that are tried and tested in mixed longitudinal cohort pre-post intervention research trials, and that can simultaneously address a wide array of identified nursing workforce problems. It is essential that these solutions involve the collaboration of all relevant stakeholders, including staff unions, professional regulatory organizations, occupational health departments, patient charter implementers, and political decision-makers, rather than excluding or fostering new sorrows upon nurses. It is essential to address suicidal impulses among suffering nurses in an empathic and reasonable manner, offering honest support and hopeful change. It is "wake-up" time for our society to embrace human goodwill, courage, and love for nurses. Proactive solutions for their distress and suffering are long overdue. In conclusion, when looking at sickness rates, outright and hidden

absences, and staff turnover, the retention and recruitment of nursing staff underscore a necessity for healthcare to address the suffering in its workplace culture. But this would be necessary in a networked, interdisciplinary fashion aimed at everyone involved, including the people leading workers, all other employees, the core of the organization such as human resources, public relations, and services, and those second and third parties connected to the organization such as any relevant professional regulatory and trade associations. Crucially, this approach would also have to bring on board the disillusioned nurses who, in truth, would probably be unlikely to participate. Perhaps what we need is action that deconstructs the metaphor of the nurse on the edge as the sole architect of their own fate, imprisoned in pathologizing identity constructs, and emphasizes the oscillations between personal and organizational suffering. We would need to consider the top-down as well as bottom-up nature of suffering in front-line nursing, uncover leadership anxieties, and navigate trodden and contested pathways to organizational membership. We see nurses as the key prerequisite in an unlimited sequence of stakeholders right from national trade associations to local healthcare facilities, HR, and back to our individual place of work. In addition, those directly and indirectly influenced by the care this nurse does or does not deliver also need to be considered.

4.1. Existing Support Systems

There are programs currently available to support nurses who are suffering as a result of negative events in the workplace. Institutions may develop a program in-house or contract with an agency to offer more formalized, confidential support. These support programs provide an organizational structure for initiatives such as peer supporter networks and a central resource location for services available to individuals or groups. Peer supporter networks may be made up of a variety of health care professionals, including nurses, who have demonstrated an ability to provide positive support to their colleagues. The training for peer supporters provides them with the skills to assist co-workers experiencing suffering related to work-related events. Many institutions have widely publicized mental health resources in addition to the internal support systems that are developed. The availability of these programs may assist in improving the overall mental and emotional resilience of the nursing staff and potentially impact rates of distress and mental illness overall. The availability of these programs has been associated with increased rates of reporting distress; however, the majority of these resources are available to all employees in the workplace and are not specific to assisting nurses and health care professionals working in the environment where the incidents occur. Indeed, one of the key limitations of the current institutional programs designed to assist nurses who are experiencing suffering is that many of them are accessed on a voluntary basis. Research demonstrates that these programs tend to attract individuals who may have knowledge and/or are comfortable accessing the supports due to having prior experiences. Therefore, the organizations must be prepared to support their staff in crisis but also establish support that is accessible and non-stigmatizing in the long term to facilitate a continuous improvement cycle. There is a limited body of research available that examines the natural supports that may assist individuals who are emotionally harmed in the workplace to recover. One of the few findings

available was a study involving nurses where it was found that linkage between organizational and natural supports was an important factor. This finding supports the larger organizational shift towards increased social support networks to foster resilience in individuals and reduce overall suffering directly resulting from adverse events. Additionally, there are institutions and individuals to emulate. Support programs in emergency rooms and pediatric settings have shown promise in preventing emotional distress by blending proactive screenings and training with focused support services for those experiencing emotional distress. They can assess, intervene, debrief, identify trends, and collectively implement change that can prevent future emotional harm.

4.2. Proposed Strategies and Interventions

Having criticized current, largely reactive strategies implemented to reduce nurses' suffering, in this section we provide a strength-based, future-oriented approach to preventing and mitigating their suffering. In general, our proposal mainly focuses on healthcare systems of the highest income countries that provide hospital-based care. However, the proposed interventions are likely to be relevant, to various extents, also to other health systems. Our proposed strategies for the prevention and reduction of nurses' suffering are based on extensive discursive analyses of nurses' suffering. These major works present multiple, interconnected issues underpinning nurses' suffering, as portrayed in the media, and discussed in government reports, academic literature, and nursing-specific social media. In these works, we have developed strategies addressing the nurse managerial and organizational level, healthcare system level, national level, and institutional level. The strategies are presented below.

To prevent the human suffering stemming from this new knowledge, tolerance of contradictions and disciplinary and individual action should be raised. This is a role nurses can play by affirming that suffering is complex and requires a multifaceted response. Although nursing is pivotal in ameliorating human suffering, the onus is not only on nursing to address this matter, which could perpetuate the unattainable expectation that nurses are the healers of the world. Healthcare leaders need to recognize that even though they have the authority to create some interventions against suffering, they also have been and could be the source of concern; thus, they also suffer. It is our opinion that professionals should conduct themselves by denouncing and conceptualizing rather than blaming colleagues. In that regard, critical, transdisciplinary autoethnographies could also be valuable in uncovering the various ways in which individuals in Southern African countries might be suffering today.

5. Conclusion

In conclusion, nurses in the healthcare system are suffering, to the detriment of their own well-being and patient care. There are numerous factors contributing to their suffering. Working short-staffed during the pandemic and taking care of critically ill patients have the greatest impact on how a nurse feels about their job. Nurse suffering in the workplace results in both personal and professional effects, which

can further impact patient care.

The triggers for nurse suffering include working in healthcare during the pandemic, dealing with chronic understaffing and negative organizational culture as a result, while indiscriminate recruitment and bursaries for those coming onto the register breed resentment and reinforce economic and moral injury. The negative personal effects of nurse suffering include poor mental and physical health, feeling undervalued, and guilt. On a professional level, there is disillusionment, rage, and low morale, accompanied by poor patient care and lack of compassion. Nurses reported a reduced ability to cope with the demands of their role and an increased likelihood of making mistakes. Staff shortages cause increased incidences of compassionate behavior from management, which creates a guilt cycle as nurses feel unable to reciprocate support. Neglectful and abusive behaviors are normalized within organizational cultures characterized as toxic, leading to further anger and hurt. Suffering experienced in the workplace can extend to other essential services that patients need to receive rehabilitative care. There is an urgent need for both qualitative and quantitative research into nurse suffering within and beyond the healthcare sector. A move away from focusing on interventions targeting individual resilience to systemic change is recommended, along with embracing a paradigm that recognizes the mutual co-dependency between staff well-being and the patient experience. Healthcare leaders and policymakers can use the results to implement specific actions.

5.1. Summary of Findings

Purpose The purpose of this scoping review was to synthesize the literature that has examined the root causes and impacts of myriad forms of suffering that nurses encounter in their work and outside of their work, from personal and professional worlds, and as products of current nursing realities and systems of organizing health care. The majority of the literature bemoans this suffering, offering suggestions about how to best manage it through support systems. Together, these findings detail a significant, yet unwelcome, reality of professional nursing that must be addressed to improve nurses' work and to ensure the highest quality of patient care. Summary of Findings Offered here is a synthesis of findings identified across the 68 papers analyzed under the same subthemes identified in the nurses' suffering. Nurses' suffering is caused by overlapping, mutually reinforcing, and collapsing systems of power and institutional expectations that continually create nursing labor as women's labor. Vendors entice nurses to work quickly. In sum, the literature examined herein posits that suffering experienced by nurses, due to personal and professional experiences of both nurses and patients, is allowed to continue because it is beneficial, if difficult to examine or articulate. Dissecting nurses' suffering thinly exposes its cause as the continual neglect of care, support, and ethical humanity in nursing work and in nursing support resources.

5.2. Implications for Practice and Policy

At its core, this study highlights the need for systemic changes to decrease the level of suffering in the workplace of nursing and to reduce the negative consequences of suffering. The findings from this study suggest organizations and those responsible

for policy should make changes to provide resources focused on helping nurses work more skillfully with suffering and develop healthy responses to suffering. This could include programs that address work-related and personal suffering. Efforts might include focusing on increasing system capacity by changing organizational practices and manager and leader conduct.

Efforts should be made to establish a culture of care that provides the best possible workplace conditions for nurses while focusing on safe standards. Best practices for nurse recruitment, orientation, support, leadership development, and retention should be established and shared, especially considering the widespread influence of workplace professionals like nurses. While it was not the intent of this study, it is noteworthy that respondents who remained satisfied and even loyal to their organizations were often the same ones who reported stress and suffering. These nurses also reported feeling a great sense of purpose in their work and of fulfillment resulting from the relationships and bedside interactions they experienced with patients and families. Future studies might explore these seemingly conflicting ideas in more depth. Also, if led by appropriate healthcare policy and organizational leaders, these findings could ideally be used by multiple stakeholder groups to advocate for change. We encourage them to act with the same degree of courage, respect, moral clarity, responsibility, and resilience that the nurses exhibited when they shared their personal stories and insights in their efforts to ignite meaningful, important, and necessary changes in their healthcare workplaces.

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