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Burnout Experiences of Nurses Working in COVID-19 and Palliative Care Units: A Comparative Qualitative Study[1]

COVID-19 ve Palyatif Bakım Servislerinde Görev Yapan Hemşirelerin Tükenmişlik Deneyimleri: Karşılaştırmalı Nitel Bir Araştırma

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Öz: Bu çalışmanın amacı, daha önce COVID-19 servislerinde çalışmış ve hâlen palyatif bakım merkezinde görev yapan aynı hemşirelerin iki bakım ortamındaki tükenmişlik deneyimlerini karşılaştırmaktır. Nitel araştırma olarak yürütülen çalışmaya 12 hemşire katılmış ve veriler yarı yapılandırılmış görüşmelerle toplanmıştır. Veriler MAXQDA kullanılarak kodlanmış, alt tema ve temalar oluşturularak analiz edilmiştir. Bulgular, tükenmişlikle ilişkili deneyimlerin bakım ortamına göre farklılaştığını göstermiştir. COVID-19 döneminde belirsizlik, enfeksiyon riski ve hızlı klinik değişimler öne çıkarken; palyatif bakımda uzun süreli bakım, tekrarlayan kayıplar ve hasta ve yakınlarıyla kurulan ilişkiler belirginleşmiştir. Mesleki başarıya yüklenen anlam da bakım ortamına göre değişmiştir. Ayrıca iş yükü, çalışma saatleri, personel yetersizliği ve örgütsel koşullar her iki ortamda tükenmişlik deneyimleriyle ilişkili bulunmuştur. Sonuçlar, tükenmişliğin bakım ortamının klinik ve örgütsel özellikleriyle birlikte değerlendirilmesi gerektiğini göstermektedir.

Anahtar Kelimeler: Tükenmişlik, COVID-19, Palyatif Bakım, Hemşirelik, Nitel Araştırma.

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Abstract: This study aimed to compare the burnout experiences of the same nurses who had previously worked in COVID-19 units and were currently working in a palliative care center across two care settings. The qualitative study included 12 nurses, and data were collected through semi-structured interviews. The data were coded using MAXQDA and analyzed by developing subthemes and themes. The findings showed that burnout-related experiences differed according to the care setting. During COVID-19, uncertainty, infection risk, and rapid clinical changes were prominent, whereas prolonged care, repeated losses, and relationships with patients and their families became more prominent in palliative care. The meaning attributed to professional accomplishment also differed between the two care settings. Moreover, work load, working hours, shortage of staff and organizational factors were linked to burnout among healthcare professionals in both care settings. The findings indicate that burnout-related experiences should be considered together with the clinical and organizational characteristics of the care setting.

Keywords: Burnout, COVID-19, Palliative Care, Nursing, Qualitative Research

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1. Introduction

The concept of burnout, originally described as a psychological response to prolonged stress and emotional labor in service professions, has been conceptualized as a multidimensional phenomenon relevant to nursing (Freudenberger, 1974; Maslach & Jackson, 1981). Continuous interaction with patients and relatives, heavy workload, and organizational pressure make nurses vulnerable to emotional exhaustion, depersonalization, and reduced personal accomplishment (Durmuş, Gerçek, & Çiftci, 2018; Kaçmaz, 2005; Sayıl, Haran, Ölmez, & Özgüven, 1997). From a health management perspective, burnout is a significant concern because it adversely affects employee well-being and may also have implications for the quality of care (Maslach, Schaufeli, & Leiter, 2001).

During COVID-19, nurses worked under high patient loads, long working hours, infection risk, and uncertainty (Fernandez et al., 2020). Studies conducted during this period, however, did not report the same burnout experiences in every healthcare setting. Gündüz Hoşgör, Çatak Tanyel, Cin, and Bozkurt Demirsoy (2021) reported low overall burnout in a mixed sample of healthcare professionals, whereas Jose, Dhandapani, and Cyriac (2020) identified moderate-to-severe emotional exhaustion and depersonalization among frontline emergency nurses. These differences suggest that burnout experiences during the pandemic may vary according to work context and exposure conditions.

Palliative care represents a long-term care context characterized by end-of-life nursing, sustained emotional demands, symptom management, and close communication with patients and their families (Alp, 2022; Andersson, Salickiene, & Rosengren, 2016; Dirimen Arıkan, 2016). Repeated exposure to end-of-life care and the emotional demands associated with palliative nursing may contribute to fatigue, difficulties in coping, and burnout-related experiences (Gómez-Urquiza et al., 2020; Okçin, 2019). In this regard, palliative care presents a different care context in which prolonged relationships with patients, repeated losses, and emotional demands become important.

From a health and nursing management perspective, the two settings also differ in patient profiles, work organization, and emotional demands. COVID-19 care was marked by crisis and uncertainty, whereas continuity of care and closer relationships with patients are more characteristic of palliative care (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Maslach & Leiter, 1997). Studies comparing the experiences of the same nurses in these two settings remain limited. Comparing the same nurses may also help distinguish changes related to the care setting from differences that might arise when separate groups are compared.

To address this gap, this study aims to comparatively examine the burnout experiences of nurses who previously worked in COVID-19 units and subsequently worked in a palliative care center. This study sought to answer the following research questions:

RQ1. In what ways do the experiences of burnout among nurses working in COVID-19 units and palliative care centers differ?

RQ2. How do nurses' experiences of emotional exhaustion, depersonalization, and personal accomplishment differ across the two contexts?

RQ3. What role do working conditions, the care environment, and organizational factors play in nurses' experiences of burnout?

1.1. Theoretical Framework of Burnout

According to Freudenberger (1974), burnout can be described as a condition of depletion as a consequence of experiencing chronic stress in relation to coping with the demands of others. Later, Maslach and Jackson (1981) defined burnout based on three dimensions that include emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach et al., 2001). Emotional exhaustion means depletion of emotional energy, whereas depersonalization implies psychological detachment from those receiving services. On the other hand, reduced personal accomplishment indicates feelings of decreased competence

and achievements in one's job performance (Arı & Bal, 2008; Kaçmaz, 2005). However, burnout does not only depend on personal factors. Job demands, role ambiguity, lack of control, and organizational injustice can affect employees as well, especially those professions where people need constant care from others (Budak & Sürgevil, 2005; Leiter & Maslach, 2003; Özkalp & Kırel, 2001).

1.2. Burnout Experienced by Nurses during the COVID-19 Period

The COVID-19 pandemic brought major changes to nurses' working conditions. High patient numbers, long working hours, exposure to infection, and uncertainty became part of their daily work and increased the demands they faced (Fernandez et al., 2020). Research conducted during the pandemic reported burnout among frontline and critical care nurses, but the findings were not the same across all samples (Almahmoud et al., 2024; Jose et al., 2020; Wan, Lian, Ma, Cai, & Xianyu, 2022). Wan et al. (2022), for example, also reported high levels of anxiety among nurses. This variation indicates that nurses' burnout experiences during COVID-19 need to be considered together with the conditions in which they worked rather than as a uniform experience of the pandemic.

1.3. Burnout Among Palliative Care Nurses

Palliative care requires nurses to work closely with patients who have life-limiting illnesses and with their families, often over an extended period. Their work includes managing complex physical and emotional needs as well as providing end-of-life care (Alp, 2022; Andersson et al., 2016; Kavalieratos et al., 2017). Working continuously with suffering, loss, and death can place considerable emotional demands on nurses (Andersson et al., 2016; Gómez-Urquiza et al., 2020). In their meta-analysis, Gómez-Urquiza et al. (2020) reported emotional exhaustion, depersonalization, and reduced personal accomplishment among nurses working in palliative care. At the same time, working in palliative care does not necessarily lead to burnout. Nurses may also find professional satisfaction and meaning in the care they provide, and their experience and training in this field may influence how they deal with its emotional demands (Okçin, 2019). Competence in end-of-life care is also relevant. Seo and Yeom (2022) found that greater end-of-life care competency was associated with lower psychological burnout, while ethical dilemmas were associated with higher burnout.

2. Method

2.1. Research Design

This qualitative study comparatively examined the burnout experiences of the same nurses in two care contexts: their previous work in COVID-19 units and their current work in a palliative care unit. The study was conducted in 2024 in the 20-bed palliative care unit of a training and research hospital in Istanbul. Because the participants had experience in both care settings, their accounts could be compared within participants. COVID-19 experiences were described retrospectively, whereas palliative care experiences reflected participants' current or more recent work context. This comparison enabled the researchers to identify similarities and differences in burnout-related experiences across the two care settings while considering their distinct clinical and organizational conditions.

2.2. Participants and Sampling

Participants were recruited using criterion sampling. This type of purposive sampling technique was suitable for this study since it was necessary to recruit nurses who had some experience in both care environments under comparison (Creswell & Poth, 2018). Thus, nurses who had been working in both COVID-19 and palliative care wards were selected and asked to take part in the study. Twelve nurses working at the palliative care ward were eligible for participation, and all of them consented to be part of the study. Thus, all eligible nurses in the unit were included in the study.

Sample adequacy was also determined with regard to data saturation. As noted by Hennink and Kaiser (2022), data saturation is typically achieved in 9-17 interviews conducted in qualitative studies involving homogeneous populations and specific aims of research. In our case, similar codes and themes started to

repeat themselves during the interviews. After data collection, reviewing the interviews showed that the key thematic framework emerged by the eighth interview. Subsequent interviews did not lead to any significant changes to this framework but just added details to it. Saturation was evaluated by the researchers together by considering the repetition of codes, subthemes, and the overall thematic structure.

2.3. Data Collection

The data collection process involved conducting semi-structured interviews using open-ended questions that had been prepared by drawing from the existing literature on the topic. Prior to the actual conduct of the interviews, two experts in the area were asked to evaluate the suitability and clarity of the questions and the final form was modified accordingly. The interview session took place in a quiet and private environment at a convenient time for the interviewee and lasted for about 45 minutes. The participants gave their consent to participate in the study.

2.4. Data Analysis and Trustworthiness

The interview data was thematically analyzed. Repeated reading of transcripts ensured familiarity with the data; meaningful statements were identified and openly coded. Common codes were then compared and clustered into sub-themes. Sub-themes and codes were constructed from the data inductively, whereas the three aspects of the burnout theory proposed by Maslach, namely emotional exhaustion, depersonalization, and reduced personal accomplishment, served as higher-level themes. Participants' COVID-19 and palliative care experiences were then compared to identify similarities and differences between the two settings.

To ensure consistency in the analysis, the first three interviews were coded separately by two researchers. The codes and sub-themes obtained by the researchers were then compared, and the differences were discussed until a common coding framework was reached. Issues that emerged during the remaining coding process were also discussed together when necessary. At the end of the analysis, the coding was reviewed once more to check its consistency. Direct quotations from the participants were also included in the findings to reflect their experiences and support the interpretations made from the data. The researchers' relationship with the research setting was also taken into account during the interpretation of the findings. One researcher had a nursing background and was working at the hospital where the study was conducted. She knew the participants working in the palliative care unit, although she had not worked with all of them during the COVID-19 period. The other researcher had an academic background in human resources and organizational behavior.

2.5. Ethical Considerations

Ethical approval for this study was obtained from the Ethics Committee of Istanbul Gelisim University (Decision No. 2024-20-39, dated December 19, 2024). Written informed consent was obtained from all participants prior to data collection, and participant confidentiality was maintained throughout the research process.

2.6. Limitations of the Study

The study was conducted in a single hospital and included 12 nurses who had experience in both COVID-19 and palliative care units. All nurses who met the inclusion criteria took part in the study. For this reason, it was not possible to balance characteristics such as gender, marital status, or professional experience for subgroup comparisons. At the request of the institution, its name was not reported. These characteristics of the study should be taken into account when considering the findings in other healthcare settings.

Another limitation concerns the timing of the participants' experiences. The interviews were conducted in 2024 while the participants were working in palliative care, whereas their experiences during the COVID-19 period were recalled retrospectively. The time that had passed since the pandemic, as well as the professional experience gained afterward, may have influenced how participants remembered and described that period. In contrast, their accounts of palliative care concerned a current or much more

recent experience. Therefore, the comparison reflects not only two different care settings but also experiences recalled from different points in time.

3. Findings

The participants' statements were read repeatedly and grouped according to the themes identified in the analysis. These themes were organized under the three dimensions of Maslach's burnout model: emotional exhaustion, depersonalization, and reduced personal accomplishment. An inductive approach was followed, as the themes emerged from the participants' statements before being organized under the three dimensions of the model. The findings were examined by comparing participants' experiences in COVID-19 and palliative care settings. The frequencies (f) shown in the tables represent the number of coded statements within each theme and sub-theme, not the number of participants who referred to them.

3.1. Socio-Demographic and Professional Characteristics of Participants

Table 1 summarizes the participants' socio-demographic and professional characteristics. It also presents their professional experience, time spent in COVID-19 and palliative care units, and weekly working hours in each setting.

Table 1: Socio-Demographic and Professional Characteristics of Participants

Participant	Age	Gender	Marital Status	Education Level	Professional Experience (years)	Tenure in Institution (years)	Palliative Care		COVID-19		Children
							Months	Hrs/ week	Months	Hrs/ week	
N1	32	Female	Married	Bachelor's	9	7	33	64	36	48	No
N2	26	Female	Single	Bachelor's	4	4	18	72	30	40	No
N3	28	Female	Married	Bachelor's	10	10	37	72	36	40	No
N4	28	Female	Married	Bachelor's	4.5	4.5	24	48-72	30	48	No
N5	27	Female	Single	Bachelor's	4	4	42	60	5	48	No
N6	29	Female	Married	Bachelor's	10.5	5	42	60	24	48	No
N7	28	Female	Single	Bachelor's	5	4	18	72	24	48	No
N8	26	Female	Married	Bachelor's	4	4	7	48-72	36	48	No
N9	31	Male	Single	Bachelor's	6.5	6.5	24	72	54	64	No
N10	31	Male	Single	Bachelor's	6	6	4	72	36	48	No
N11	32	Female	Married	Associate Degree	10	10	36	72	12	48	Yes
N12	38	Male	Married	Bachelor's	13	5	36	48	24	48	Yes
Mean	**30**	**75% Female**	**58% Married**	**92% Bachelor's**	**7.2 years**	**6.6 years**	**24 months**	**65.3 hours**	**27.08 months**	**48 hours**	**%83 No**

Note: N indicates Nurse (participant code). Marital and parental status are presented as contextual information and were not interpreted as independent analytical themes.

Participants had a mean age of 30 years and an average of 7.2 years of professional experience. Their average tenure at the institution was 6.6 years. They had worked for approximately 27 months in COVID-19 units and 24 months in palliative care. Although they had considerable experience in both settings, their weekly working hours differed. Weekly working hours averaged 48 hours during the COVID-19 period and 65.3 hours during the palliative care period. This difference can be understood in relation to changes in staffing and shift arrangements. During the pandemic, shifts were arranged with longer intervals between hospital attendance to limit staff contact. By the time the nurses were working in palliative care, several staff members had completed their compulsory service and transferred to other institutions, while the number of newly assigned nurses was lower. This resulted in longer weekly working hours during the palliative care period.

3.2. Emotional Exhaustion

Participants described emotional exhaustion in relation to psychological and organizational factors. The sub-themes, participant distributions, and coding frequencies are presented in Table 2.

Table 2: Emotional Exhaustion Subthemes in COVID-19 and Palliative Care (n = 12)

Burnout Dimension			COVID-19 Units		Palliative Care Services	
Main Theme		**Sub-theme**	**Representative Nurses**	**f**	**Representative Nurses**	**f**
Emotional Exhaustion	**Psychological Factors**	**Empathy fatigue (–)**	N1, N4, N6, N7, N8, N10, N11, N12	20	N1, N9, N11, N12	24
		Excessive emotional load (–)	N1, N2, N8, N10, N12	16	N1, N2, N4, N6, N7, N9, N12	20
		Uncertainty (–)	N1, N2, N3, N6, N8, N10, N12	16	—	—
		Fear (–)	N1, N2, N4, N6, N7, N10, N12	9	N1, N4, N8, N11	5
		Helplessness (–)	N5, N6, N9, N12	7	N3, N6, N9, N10, N12	7
	Organizational Factors	**Workload (–)**	N1, N2, N7, N9, N12	17	N2, N3, N7, N9, N12	17
		Long working hours (–)	N1, N2, N7, N9, N12	5	N2, N3, N7, N9, N12	5
		Managerial factors (–)	N1, N2	3	N2, N7, N10	5
		Interaction with patient relatives (–)	N1, N12	18	N1, N12	25
		Professional boundary setting (–)	N1, N2	9	N1, N2, N4, N6, N8, N11, N12	20

Note: f represents coded statements rather than participants; thus, one participant may contribute multiple statements to a subtheme. Participant IDs identify contributing nurses.

3.2.1. Psychological Factors

Psychological factors included empathy fatigue, excessive emotional load, uncertainty, fear, and helplessness. Some of these were experienced in both settings, but the reasons behind them were not always the same.

Empathy fatigue was experienced in both settings. During COVID-19, N1 described empathy together with the fear of experiencing the same situation: *"You inevitably empathize a great deal and think, 'What would I do if this happened to me?'"* N1 also described the rapid deterioration and death of mostly younger COVID-19 patients as more distressing than similar experiences in palliative care. In palliative care, the same participant described a different experience: *"At first, I became very attached to palliative care patients, but I saw that this made me very sad and exhausted me. Over time, I understood how psychologically harmful this was for me."* These two statements show that empathy fatigue was experienced differently: through identification with patients during COVID-19 and through emotional attachment in palliative care.

Excessive emotional load was also present in both settings. N1 viewed both cases as very stressful from a psychological perspective, but highlighted that the young age of patients with the disease and their quick deterioration were major issues: *"Because COVID-19 patients were generally young, when they did not recover, deteriorated, went to intensive care, or died, it was more upsetting and exhausting compared with palliative care patients."* Although emotional load was experienced in both settings, N1 associated the COVID-19 period particularly with younger patients, rapid deterioration, and unexpected loss.

Uncertainty was only mentioned in relation to the COVID-19 period. Especially at the beginning of the pandemic, nurses had limited knowledge about the disease, its course, and treatment. N10 stated, *"The fact that COVID-19 was a new disease and its treatment was not fully known made us feel inadequate."* As their knowledge and experience increased, this uncertainty decreased. Participants did not describe a similar experience of uncertainty in palliative care.

Fear was present in both settings for different reasons. During COVID-19, participants mainly referred to death and transmission. N1 stated, *"What affected me most was the fear of infecting both myself and someone else because of me; it was psychologically very exhausting."* In palliative care, N1 instead referred to aging, dependency, and the possibility that the participant's parents might one day need similar care.

Helplessness was reported in both settings. N6 stated, *"In both situations, there was only a certain point up to which we could intervene. This left me feeling helpless."* During COVID-19, N6 related this feeling particularly to the rapid deterioration of patients without previous chronic illness and added, *"I wish there was something more we could have done."* In palliative care, helplessness was described when little could be done to change the patient's condition or relieve suffering.

3.2.2. Organizational Factors

Workload was reported in both care settings, although the conditions associated with it differed. During COVID-19, workload was associated with patients' high care needs and dependency. N1 stated, *"COVID-19 patients had very high oxygen needs, so they could not meet their needs on their own and needed someone to care for them. Because they remained bedridden for a long time, pressure sores developed very quickly. For these reasons, they experienced severe pain and oxygen deprivation, which increased their dependency and care needs."* N7 also stated that *"the very high expectations from us nurses increase our burnout."* In palliative care, workload was more closely associated with prolonged and intensive care needs. N2 described how difficulties surrounding the care of patients increased nurses' workload: *"Because patients in the palliative care center stay for a long time, their care is very difficult and they are older, disagreements arise within the family about who will provide the care. The person staying with the patient is therefore very reluctant, which makes it difficult for us to do our job, increases our workload even more, and causes anger toward patient relatives."*

Long working hours were reported in both settings. During COVID-19, N1 referred to *"intensive and long working hours [and] working in a closed environment,"* while N2 stated, *"Our working hours were too long."* N7 similarly identified *"long working hours,"* N9 *"our prolonged working hours,"* and N12 *"long and shift-based working hours."* Similar statements were made in palliative care. N2 again referred to *"our long working hours,"* N3 and N7 both identified *"long working hours,"* N9 referred to *"our prolonged working hours,"* and N12 described *"long and shift-based working hours."* Long working hours were therefore a common organizational factor in participants' accounts of both care settings.

Managerial factors were identified in both care settings. N2 described several organizational difficulties as common to both settings, including long working hours, inadequate working conditions, insufficient staffing relative to the number of patients, low pay, and insufficient material and emotional return for nurses' work. During COVID-19, N1 additionally referred to *"intensive and long working hours, working in a closed environment, receiving low pay for the work performed, and the lack of sufficient equipment in the early period of COVID-19."* In palliative care, N7 referred to *"unsuitable working conditions,"* while N10 identified *"the high number of patients being cared for"* and *"a very intensive work pace."*

N2's account also applied to palliative care, particularly in relation to insufficient staffing, long working hours, inadequate working conditions, and the imbalance between nurses' workload and the material and emotional return they received. Managerial factors were therefore associated mainly with staffing, workload, working conditions, resources, and the material and emotional return of nurses' work.

Interaction with patient relatives was difficult in both settings, but for different reasons. During COVID-19, N1 described how fear of transmission affected relatives' participation in patient care: *"This also happened with patient relatives; because they were afraid that they would become infected, they did not want to care for their patients."* In palliative care, the same participant explained that relatives had difficulty participating in the care of patients who required more support: *"Because the general condition of palliative care patients was very poor, their care was very demanding. Patient relatives had great difficulty with care and many of them did not want to provide it."* N1 also stated, *"It takes time for them to accept that what we do is for educational purposes and that they need to take an active role in patient care. Patient relatives are very resistant to receiving education and learning."* These statements show that difficulties with patient relatives were

experienced in both settings. During COVID-19, the main problem was fear of transmission, while in palliative care the difficulties were related to participation in patient care and resistance to care education.

Professional boundary setting (–) referred to difficulty maintaining emotional boundaries with patients and their relatives. This was identified in both settings but was described more often in relation to prolonged contact in palliative care. N1 stated, *"Because patients in the palliative care center have longer hospital stays, we spend more time with patients and their relatives. When this happens, a stronger bond develops."* The same participant explained its emotional effect: *"At first, I formed very strong bonds with palliative care patients, but ... this made me very sad and exhausted me."* N2 similarly stated, *"...I spent more time with patients and their relatives and formed stronger bonds. The patient's deterioration and eventual death affected me more psychologically."* N6 also described longer contact as leading to closer communication. In contrast, conscious efforts to limit emotional involvement were coded separately as professional boundary setting (+) under depersonalization.

3.3. Depersonalization

Professional boundary setting and emotional numbing were evaluated separately under the depersonalization dimension. Professional boundary setting concerned efforts to regulate emotional closeness with patients and their families. Emotional numbing concerned a reduction in emotional response after repeated exposure to suffering and patient loss and was considered more closely related to the distancing aspect of Maslach's depersonalization dimension. Table 3 presents the distribution of these subthemes across the two care settings.

Table 3: Depersonalization Subthemes in COVID-19 and Palliative Care (n = 12)

Burnout Dimension		COVID-19 Period		Palliative Care Unit	
Main Theme	**Sub-theme**	**Representative Nurses**	**f**	**Representative Nurses**	**f**
Depersonalization	**Professional boundary setting (+)**	N3, N6, N7, N8, N9	5	N1, N3, N4, N9	10
	Emotional numbing (–)	—	—	N2, N4, N5, N8, N9, N10, N12	12

Note: f represents the number of coded statements, not participants; therefore, the same participant may contribute more than once to a subtheme. Participant IDs indicate the nurses contributing to each subtheme.

3.3.1. Professional Boundary Setting (+) Across Care Contexts

Professional boundary setting (+) was present in both settings for different reasons. During COVID-19, it was mainly related to infection risk and isolation. N6 stated, *"During the COVID-19 period, I limited my communication with patients and their families as much as possible because of the possibility of infection."* N8 described a similar experience: *"Because of isolation and the high risk of transmission during COVID-19, I did not have much contact with patients and their relatives except when necessary."*

In palliative care, longer contact with patients created a different problem. Some participants described trying to control the emotional closeness that developed over time. N1 explained this change directly: *"Being very upset after every patient who died exhausted me. This is my profession and I will be doing it for many years, so I realized that I could not continue like this. I began doing everything I could for patients and their relatives, but tried not to form a bond or empathize too much."* N4 similarly described consciously limiting emotional closeness while continuing to provide care: *"Although a certain familiarity sometimes developed with patients' relatives, I generally tried not to form an emotional bond so that I could do my job properly."* N9 also described not forming close relationships with patients and their relatives as part of a professional approach: *"I approach it as my job, so I do not form too much of a bond with patients and their relatives. I do not consider it necessary."* At the same time, N9 stated that being unable to help some patients still led to feelings of professional inadequacy: *"I try not to form any bond, but when I cannot intervene for some patients, when there is nothing I can do for that patient and I cannot find a solution, it makes me wonder whether I am inadequate."* N9's accounts show that maintaining professional distance did not necessarily mean an absence of concern about the patient or the care provided.

Professional boundary setting (+) therefore took different forms across the two settings. During COVID-19, participants described limiting interpersonal contact under conditions of infection risk and isolation. In palliative care, N1, N4, and N9 described deliberately regulating emotional involvement in the context of prolonged contact and repeated losses. In both cases, professional boundary setting involved regulation of closeness while continuing to provide care and was therefore distinguished from emotional numbing.

3.3.2. Emotional Numbing as a Context-Specific Response

Emotional numbing was not identified in the COVID-19 accounts. In palliative care, statements from N2, N4, N5, N8, N9, N10, and N12 were coded under this subtheme. Participants did not describe this experience in exactly the same way.

N4 described this change strongly: *"I realized that I was facing the most painful side of my profession and that being unable to do anything while people were suffering was beginning to take away my emotions and my ability to empathize."* N9 similarly described becoming less emotionally affected after repeated exposure to death: *"Over time, because I have seen so many deaths and witnessed all of their difficult moments, I can say that I do not feel as sad as I used to."*

Other participants also described changes in their reactions to patient death and the expected clinical course. N2 stated, *"When it was certain that the patient would not recover, thinking that those who died were finally at peace and would no longer suffer so much could even feel relieving, although this may sound bad to someone who has not experienced it."* N12 expressed a very similar experience: *"Although the death of some patients made us sad, seeing how much they had suffered and knowing that their pain had finally ended relieved me, even though it was still something bad."*

N8 associated this change with becoming accustomed to the expected course of palliative care: *"In palliative care, because the patients and their relatives had accepted the situation, I began to consider many things normal."* N8 also stated, *"When caring for palliative care patients, I feel less sad compared with COVID-19 patients."* N10 explained that palliative care generally involved older patients with multiple chronic illnesses and limited possibilities for recovery, adding that because treatment was directed toward comfort, *"we nurses also did not have very high expectations from the patient."*

N4 and N9 referred more directly to reduced emotional responses. N8 and N10 described becoming accustomed to the clinical course of patients, while N2 and N12 referred to changes in the way they viewed death after prolonged suffering. These experiences were evaluated separately from deliberate professional boundary setting.

3.4. Decline in the Sense of Personal Achievement

Five subthemes were identified under the main theme of "Decline in the Sense of Personal Achievement": questioning professional competence, efforts perceived as being in vain, professional fulfillment/achievement, decline in job satisfaction, and self-efficacy. Similar experiences were found in both care settings, although the participants did not always describe professional achievement in the same way. Table 4 presents the subthemes, participant distributions, and coding frequencies.

Table 4: Subthemes of Decline in Personal Achievement (n = 12)

Burnout Dimension		**COVID-19 Period**		**Palliative Care Unit**	
Main Theme	**Sub-theme**	**Representative Nurses**	**f**	**Representative Nurses**	**f**
Decline in the Sense of Personal Achievement	Questioning professional competence (–)	N5, N6, N9, N10, N11, N12	6	N4, N7, N8, N10, N12	5
	Efforts perceived as being in vain (–)	N2, N4, N12	3	N1, N2, N3, N4, N8, N10, N12	8
	Professional fulfillment/ achievement (+)	N1, N2, N3, N4, N5, N6, N8, N9, N10, N11, N12	19	N1, N2, N5, N6, N7, N9, N10, N11, N12	20

	Decline in job satisfaction (–)	—	—	N8, N10, N11	3
	Self-efficacy (+)	N2, N5, N10, N12	4	N10, N12	2

Note: f represents the number of coded statements, not participants; therefore, the same participant may contribute more than once to a subtheme. Participant IDs indicate the nurses contributing to each subtheme.

During COVID-19, professional achievement was more often associated with recovery, discharge, and clinical improvement. In palliative care, participants also referred to reducing suffering, providing comfort, and meeting patients' care needs.

3.4.1. Questioning Professional Competence

Questioning professional competence appeared in both settings. During COVID-19, participants referred particularly to uncertainty and rapid deterioration. N6 stated, *"No matter what we did, the outcome didn't change…"* and described feeling inadequate when patients deteriorated rapidly, adding, *"I wish there was something more we could have done."* N11 similarly stated, *"…the fact that nothing came of our efforts led me to feel professionally inadequate. Even though I had done everything possible, the fact that they didn't improve but instead got progressively worse left deep wounds in my heart."*

N10 and N12 described questioning their professional competence in both settings. During COVID-19, N10 referred to *"…seeing patients unable to breathe in front of us, experiencing respiratory distress, and not knowing clearly what treatment should be given."* In palliative care, feelings of inadequacy were described when available interventions could not relieve severe pain despite the expectations of patients and their relatives. N12 also described similar feelings in both periods. During COVID-19, the participant stated, *"You work hard for days on end, but when a patient ultimately dies, you question everything you've done."* In palliative care, feelings of inadequacy were again associated with situations in which the care provided could not change the patient's condition.

3.4.2. Efforts Perceived as Being in Vain

The feeling that efforts were in vain appeared in both settings. N2, N4, and N12 referred to this experience in both COVID-19 and palliative care. N2 stated, *"In both situations, after making so much effort and putting so much work into the patient, seeing the outcome end in death makes you feel very bad. It gives you the feeling that everything you have done has been in vain..."* In palliative care, longer care periods and closer relationships with patients sometimes made patient loss more difficult for participants.

N4 described a similar feeling: *"It is saddening, exhausting, and sometimes very hurtful to see that so much effort and hard work have no return..."* N4 explained that when patients no longer had expectations about their condition, it became more difficult to see the results of nursing interventions. N12 also related this feeling to patient loss in both settings, describing *"sadness, disappointment, helplessness, inadequacy, and loss of motivation."* In palliative care, prolonged care made this feeling stronger: *"You care for and treat a patient for months, and then the patient dies. The effort you have given feels wasted..."*

3.4.3. Professional Fulfillment/Achievement

Professional fulfillment/achievement was present in both settings, but its source differed. During COVID-19, participants more often associated professional fulfillment with recovery and discharge. N1 stated that seeing patients recover and return home increased professional satisfaction. The same participant described seeing severely ill patients leave the unit in good health as professional fulfillment. N2 similarly stated, *"The recovery rate during the COVID period satisfied me to a great extent in terms of professional fulfillment."* N6 described a similar experience, particularly because many COVID-19 patients were young: *"We made an effort together with all our nurse colleagues because we really wanted the patients to recover. When we saw them getting better, it felt as if one of our own relatives had recovered."*

Professional fulfillment was also reported in palliative care, although recovery was not always possible. N10 stated, *"The recovery of patients in both groups makes us very happy. Seeing that our care and effort have a*

positive result and that our nursing practices are successful makes us feel professionally honored." In palliative care, participants could also associate professional achievement with smaller improvements and the care provided to patients. N12 similarly associated positive patient outcomes with professional achievement in both settings, stating, *"The recovery of patients in both groups brought great happiness, hope, optimism, and a sense of achievement. Every patient who recovered made us forget our tiredness and reminded us once again of the value of our profession."* Participants' palliative care accounts also associated professional fulfillment with reducing suffering, improving comfort, and providing care. During COVID-19, recovery and discharge provided a more visible outcome of nurses' efforts. In palliative care, professional fulfillment was also associated with smaller improvements, reducing suffering, and the care provided to patients.

3.4.4. Decline in Job Satisfaction

Decline in job satisfaction was identified only in the palliative care accounts of N8, N10, and N11. Repeated patient losses, limited possibilities for recovery and discharge, and difficult interactions during the care process were prominent in these accounts. N8 associated the decline in professional satisfaction with the limited possibility of positive patient outcomes in palliative care, stating, *"Because recovery and discharge are very rare, my professional satisfaction decreases considerably."* N10 similarly emphasized repeated losses after prolonged care: *"Losing a patient we have cared for for months and frequently experiencing patient deaths in the palliative care unit creates professional dissatisfaction."* For N8 and N10, declining job satisfaction was therefore associated with the limited possibility of seeing a positive outcome after providing care. N11 described another source of professional dissatisfaction, stating, *"In both processes, because we had extensive contact with patients and their relatives, disrespectful attitudes toward us when a problem occurred damaged our profession."* Within the palliative care experience, negative interpersonal interactions were therefore another factor associated with professional dissatisfaction.

3.4.5. Self-Efficacy

Self-efficacy was expressed in both care settings, although by fewer participants than the other subthemes. N10 and N12 expressed self-efficacy in both COVID-19 and palliative care, while N2 and N5 described this experience during COVID-19. During COVID-19, self-efficacy was particularly associated with gaining knowledge and experience over time. N2 stated that the lack of knowledge about the disease and its high transmissibility initially caused considerable anxiety, but added that *"as time passed and we learned more about the disease and its care, my anxiety decreased."*

N5 described a similar change, stating that after becoming accustomed to the hospital and patient care process, the participant's perspective changed and the experience was no longer as affecting as before. These accounts associated increasing familiarity with the disease and care process with a greater sense of control during COVID-19. N12 expressed self-efficacy in both settings and referred to an increased sense of responsibility and awareness of professional duties. For N12, self-efficacy was therefore not limited to adapting to COVID-19 conditions but was also present in the subsequent palliative care experience. N10 also expressed self-efficacy in both settings and associated it with positive outcomes from nursing care: *"The recovery of patients in both groups makes us very happy. Seeing that our care and effort have a positive result and that our nursing practices are successful makes us feel professionally honored."* For N10, successful nursing practices and seeing positive outcomes were associated with a sense of professional capability across both care settings.

4. Discussion

Burnout-related experiences were present in both settings, but under different conditions. During COVID-19, participants frequently referred to uncertainty, infection risk, and rapid changes in patients' clinical conditions. Previous studies have reported similar difficulties during the pandemic (Fernandez et al., 2020; Galanis, Vraka, Fragkou, Bilali, & Kaitelidou, 2021; Jose et al., 2020). Turgut, Güdül Öz, Akgün, Boz, and Yangın (2022) also reported problems related to uncertainty about the disease and its treatment.

In palliative care, uncertainty was less prominent. Prolonged contact with patients, repeated deaths, and limited possibilities for recovery were more evident. Patient suffering, death, and close relationships with patients and relatives have also been discussed in previous palliative care studies (Andersson et al., 2016; Gómez-Urquiza et al., 2020).

Working conditions differed considerably between the two periods. Previous studies have associated workload, long working hours, staff shortages, and organizational support with burnout (Demerouti et al., 2001; Galanis et al., 2021; Maslach et al., 2001). In the present study, weekly working hours averaged 48 hours during COVID-19 and 65.3 hours in palliative care. This difference should be kept in mind when interpreting workload and emotional exhaustion.

Professional boundary setting occurred in both settings. During COVID-19, it was mainly related to infection risk. In palliative care, some participants described limiting emotional closeness after long-term contact with patients and repeated losses. Previous palliative care studies have also addressed emotional involvement and professional relationships (Andersson et al., 2016; Okçin, 2019).

Emotional numbing was found only in palliative care accounts. Participants described this in different ways, including becoming less affected by repeated deaths and changing how they viewed expected death and prolonged suffering. These experiences were related to the distancing aspect of Maslach's depersonalization dimension, but depersonalization itself was not measured in this study. Emotional numbing was therefore not treated as evidence that participants had developed depersonalization.

Professional accomplishment also had different meanings across the two settings. During COVID-19, recovery, improvement, and discharge were more visible indicators of accomplishment. In palliative care, reducing suffering, providing comfort, and meeting care needs could also be meaningful. Some participants nevertheless questioned their competence when the patient's condition could not be changed. Similar experiences of meaning and professional satisfaction in palliative care have been reported by Andersson et al. (2016) and Okçin (2019).

A particular feature of this study was that the same nurses described both care settings. Differences could be examined within the nurses' own experiences rather than between two independent groups. However, care setting is not the only difference between the two periods. COVID-19 was recalled retrospectively, palliative care was more recent, and working conditions also differed.

5. Conclusion and Implications

The findings showed that burnout-related experiences differed between the COVID-19 and palliative care periods, even among the same nurses. During COVID-19, uncertainty, infection risk, and rapid changes in patients' conditions were more prominent. In palliative care, prolonged relationships with patients, repeated losses, and continuing emotional demands were more evident.

The meaning of professional accomplishment also changed according to the care setting. During COVID-19, recovery and discharge were clearer signs of a positive outcome. In palliative care, relieving suffering, providing comfort, and meeting care needs could also give nurses a sense of professional satisfaction even when recovery was not expected. However, repeated patient losses also led some participants to question whether their efforts were sufficient or meaningful.

Workload, staff shortages, and long working hours affected both periods. Professional boundary setting was also present in both settings, although it developed for different reasons. The findings also showed that professional boundary setting and emotional numbing should not be considered the same experience.

Overall, the findings show that burnout-related experiences cannot be considered separately from the clinical and organizational conditions in which nurses work. Longitudinal and comparative studies may provide a clearer understanding of how changes in workload, staffing, and organizational support affect these experiences over time.

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