The Cost of Caring

Exploring How Work Environment, Leadership, and Employer Branding Shape Nurses' Attitudes and Turnover-Related Behavior

SAGA SUNEBÄCK
AMELIA MALM

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Abstract

The nursing profession is progressively portrayed in Swedish media as being in a state of crisis, marked by staff shortages, high turnover, heavy workload, and emotionally demanding working conditions. Simultaneously, nursing is among the most important professional groups within healthcare, where organizational stability and employee retention are fundamental for maintaining patient safety and the quality of care. Therefore, this thesis examines how organizational and internal marketing-related factors influence nurses' attitudes and turnover-related behavior across hospital and primary healthcare settings, as well as why nurses ultimately choose to stay within or leave their workplace or the profession as a whole. Particular attention is given to how organizational structures, workplace relationships, and external portrayals of the profession shape nurses' experiences. Utilizing an exploratory qualitative design, data was gathered through 20 semi-structured interviews with registered nurses across Swedish hospital and primary care settings. The findings indicate that nurses' willingness to stay is strongly connected to whether organizational conditions allow them to provide meaningful and sustainable care. While social support, patient interactions, and high levels of intrinsic motivation function as important resources, the daily work also involves high demands including high workload, understaffing, administrative burden, and dissatisfaction with leadership. This contributes to stress, moral distress, and turnover-related behavior. The study concludes that nurse turnover is primarily driven by weak organizational and managerial conditions instead of a lack of professional commitment, resulting frequently in horizontal mobility rather than a complete withdrawal from the field.

Keywords:

Nurse retention, leadership, work environment, employer branding, Swedish healthcare

Authors:

Saga Sunebäck (26105)

Amelia Malm (26021)

Tutor	**Examiner**
Jonas Colliander	Magnus Söderlund
	Per Andersson

Table of Contents

1. Introduction

1.1 The crisis

“Four out of ten young people do not believe they will continue working in healthcare” (Vårdförbundet, 2024), “Nurses are fleeing the clinical floors” (Vårdfokus, 2021), and “Burned-out healthcare worker raises alarm for crying at work after 17-hour shifts” (Dagens Nyheter, 2025). Headlines like these have become a permanent portrayal of the Swedish healthcare system in Swedish media. The media frequently presents a picture of total systemic collapse, driven by overwhelming burnout and a collective departure from the clinical floor. This dominant external narrative paints a uniform picture of a profession in acute crisis, suggesting that chronic staffing shortages and overwhelming stress are driving nurses to abandon their profession entirely. This media perspective is highly important for future discussion, as it shapes both public perception and policy priorities; however, it risks substantially oversimplifying the crisis. By treating "nursing" as a monolithic experience, this narrative assumes that the demands, stressors, and reasons for leaving are identical across the entire healthcare spectrum, thereby overlooking the nuanced, lived reality of the healthcare workforce.

Beyond the media headlines, the organizational reality is deeply complex. Healthcare systems globally are facing increasing challenges related to workforce shortages and the retention of qualified professionals. Nurses represent one of the largest professional groups within healthcare organizations and play a central role in the delivery of patient care. High levels of nurse turnover lead to increased recruitment and training costs, disruptions in healthcare teams, and challenges in maintaining continuity of care (Halter et al., 2017). Consequently, maintaining a stable nursing workforce is essential for ensuring healthcare quality and patient safety.

The issue of nurse retention has become particularly urgent within the Swedish healthcare context. Reports from professional organizations highlight profound concerns regarding working conditions, staffing levels, and workload among nursing staff (Vårdförbundet, 2023). These reports indicate that friction experienced by nurses rarely stems from a desire to abandon patient care itself. Many entered the field driven by a strong vocational calling. Instead, the core conflict lies in an increasing intolerance for unsustainable organizational environments. Nurses are not necessarily losing their dedication to healthcare; rather, their

willingness to remain is heavily dictated by the specific organizational conditions of their workplaces.

1.2 Structural Differences: Hospitals vs. Primary Healthcare

To move beyond the monolithic view of the nursing crisis and understand the mechanisms driving turnover, it is necessary to examine the distinct organizational environments in which nurses operate. Healthcare services in Sweden are delivered through a decentralized, regionally-owned structure. Under this model, 21 independent regions hold the primary responsibility for financing and providing care, which is largely divided between specialized hospital-based care and primary healthcare (PHC) services. Contrasting these two settings reveals fundamentally different working conditions, structural pressures, and professional responsibilities.

Hospitals provide specialized and acute medical care. These settings are typically characterized by 24/7 operations, unpredictable acute patient flows, high-intensity clinical environments, steep medical hierarchies, and the physical and social toll of shift-based schedules (Swedish Agency for Work Environment Expertise, 2023). In contrast, primary healthcare often serves as the first point of contact within the system. It operates primarily during daytime hours with planned patient visits, offering greater schedule predictability. Primary care nursing is often associated with long-term patient relationships, coordinating care for patients with complex needs, and supporting long-term disease management (Karam et al., 2021).

However, primary care is simultaneously burdened by immense accessibility pressures, stringent budget constraints, and the heavy cognitive load of serving as the initial diagnostic gatekeeper for a growing population (Khatri et al., 2023). While both environments suffer from staffing shortages, the structural mechanisms that trigger stress, and the resources required to mitigate it, differ significantly between hospitals and primary care centers (Socialstyrelsen, 2025). Understanding these structural differences is essential to understanding why nurses ultimately choose to stay in, move within, or leave the healthcare system entirely.

1.3 Problematization and the Research Gap

The distinction between leaving a specific organization and leaving the profession entirely presents a critical challenge for healthcare management. High turnover at the workplace creates a compounding cycle that increases the workload for remaining staff, inflates recruitment costs, and ultimately threatens the quality of care. Historically, turnover research has relied on a "one-size-fits-all" perspective. However, modern scholarship emphasizes the need for context-specific investigations that account for the unique boundary conditions of specific industries (Hom et al., 2017).

Despite the urgency of this issue, there remains a noticeable gap in qualitative research examining how organizational determinants shape workplace-specific turnover within the Swedish healthcare system. Specifically, there is limited knowledge regarding how nurses' attitudes and behaviors are influenced differently by their clinical environment. Swedish primary healthcare represents a unique contextual laboratory where traditional rational-choice models often fail due to rigid public sector budget constraints. Furthermore, the nursing profession is defined by a professional identity that prioritizes patient care, often described as the warm glow, over individual utility (Marold et al., 2025).

A critical research gap exists regarding how internal marketing (B2E) functions when the product sold to the employee, which is the ability to provide care, is compromised by organizational failures. We do not yet fully understand which organizational factors most strongly influence the decision to stay or leave in a setting where traditional corporate attractiveness is structurally unavailable. As highlighted by Vårdförbundet (2025), an increasing administrative burden decreases time for patient care, causing the brand promise of clinical work to be replaced by a reality of documentation.

While existing Swedish reports confirm the "what", noting that over 40% of young healthcare workers do not believe they will remain in the profession (Arnell-Szurkos and Björkman, 2024), the "why" remains uncertain. Most prior literature has focused on general burnout, leaving a gap in our understanding of how organizational dynamics and turnover-related behaviors differ specifically between hospital and primary care settings. By rejecting a universal approach and investigating the underlying motivations that drive nurses to stay or leave, this thesis provides the fine-grained prediction necessitated by modern scholarship (Hom et al., 2017). Furthermore, qualitative research is essential to uncover how these

organizational factors impact nurses differently, depending on their clinical environment (Högberg et al., 2023).

1.4 Research Purpose and Research Questions

The purpose of this thesis is to explore the organizational factors that influence nurse retention and turnover-behaviors within the Swedish healthcare system. By comparing the lived experiences of nurses in hospitals with those in PHC, the study aims to uncover how structural differences between clinical settings shape professional sustainability.

To fulfill this purpose, the study addresses the following research questions:

1. *How do organizational factors influence nurses' attitudes and turnover-related behavior, and how do these experiences differ between hospital and primary healthcare settings?*
2. *Why do nurses ultimately decide to stay within or leave their job or the nursing profession?*

2. Literature Review and Conceptual Framework

The following review examines previous research surrounding employee turnover and retention, specifically regarding the nursing profession. It transitions from general management and marketing theories to the specific challenges within the Swedish healthcare system, identifying the current research gaps that this study intends to address.

2.1 Retention and Turnover

The study of employee turnover has evolved from a simple metric of workforce stability into a complex analysis of organizational health. Generally, turnover is defined as the termination of membership in an organization by an individual who received monetary compensation (Price, 1977). Within management literature, a critical distinction is made between involuntary turnover, initiated by the employer, and voluntary turnover, initiated by the employee. Voluntary turnover is the primary concern for organizational research, as it often signals underlying failures in leadership, culture, or the "internal product" of the job itself.

In contrast to turnover, employee retention represents an organization's capacity to maintain workforce stability by fostering long-term commitment among its staff (Lakshmi and

Jayathilaka, 2023). Retention is not merely the absence of turnover. Rather, it represents a proactive organizational outcome resulting from policies and a culture that fosters long-term commitment. In contemporary research, this is increasingly analyzed through internal marketing, which posits that for an organization to satisfy its external customers, it must first satisfy its internal customers (employees) by viewing the employment offering as a product that must meet their needs.

2.2 Global Trends in Nursing Turnover

In the healthcare sector, a global shortage of qualified professionals has fundamentally shifted the power dynamic between employer and employee. The nursing market is currently characterized by a seller's market, where nurses possess high market power due to the scarcity of specialized clinical skills. Consequently, the retention threshold has lowered; research suggests that nurses are more likely to exit an organization over psychological contract breaches because they face a generalized perception that finding another acceptable job within nursing would be relatively easy (Gulzar et al., 2022).

2.2.1 The "Loyal-but-Leaving" Paradox

A recurring phenomenon in nursing literature is the tension between professional identity and organizational belonging. Nurses often report high levels of occupational commitment, a deep dedication to patient care and the nursing vocation, while simultaneously experiencing low organizational commitment. Research indicates that nurses often feel that their formal competence and senior expertise are not valued, leading to a feeling of being "merely a brick in the game" (Bäckström et al., 2024). This creates a "loyal-but-leaving" paradox, where staff exit an organization not because they wish to leave nursing, but because the organizational structure prevents them from practicing according to their professional standards (Halter et al., 2017).

2.2.2 Structural Differences: Hospital versus Primary Care

The Swedish healthcare system is organized into two distinct structural models. Hospital environments are defined by a 24-hour operational requirement, necessitating rotating shift work and continuous patient surveillance. This structure is designed for high-intensity, reactive care where patient inflow is largely unpredictable.

Conversely, primary healthcare operates on a standard office-hour model, with clinical activities typically restricted to mornings and afternoons (Dall'Ora et al., 2023). Unlike the acute hospital intake, PHC utilizes appointment-based scheduling and triage systems to regulate patient throughput. This creates a more predictable distribution of volume across a fixed daily timeframe, shifting the structural focus from bedside intervention to patient navigation and coordination (Swedish Agency for Work Environment Expertise, 2023).

2.3 Organizational Determinants of Turnover

The decision to remain in or exit a healthcare organization is influenced by a complex interplay of structural and psychological factors.

2.3.1 Work Environment and the JD-R Model

The Job Demands-Resources (JD-R) model provides a dominant framework for understanding turnover by categorizing work characteristics into demands and resources (Bakker & Demerouti, 2007). Job demands, such as time pressure and emotional labor, require sustained effort and involve psychological costs, while job resources may help reduce demands, support goal achievement, and foster motivation. The health impairment process within the JD-R model helps explain the potential consequences of an imbalance between job demands and resources. Prolonged exposure to high demands, particularly when resources and recovery opportunities are insufficient, gradually increases the risk of fatigue and emotional exhaustion (Bakker and Demerouti, 2007). Recent literature concerning the Swedish healthcare sector suggests that administrative documentation and digital systems, such as '1177 Direct,' often act as hindrance demands (Vårdförbundet, 2025). These systems can increase workload and stress without necessarily streamlining workflows for frontline staff, frequently culminating in moral distress: the psychological pain of being unable to provide high-quality care due to systemic constraints.

As an extension of the JD-R perspective, the Demand-Induced Strain Compensation Recovery (DISC-R) framework further suggests that resources are most effective when they match the type of demand experienced by employees (De Jonge and Dorrman, 2006). For example, emotional demands are more likely to be buffered by emotional resources, such as social support, while cognitive or physical demands may require different forms of resources. This distinction is relevant in healthcare settings, where employees often face simultaneous emotional, cognitive, and organizational demands.

2.3.2 Leadership and Bureaucratic Distance

Leadership practices serve as a primary determinant of job satisfaction and retention. While supportive leadership is known to increase retention, many healthcare systems suffer from bureaucratic distance (Dellve, 2017). This refers to the gap between local unit managers and higher-level regional administration. Research indicates that when leadership fails to mitigate role stressors (ambiguity, conflict, and overload), affective organizational commitment diminishes, leading to an increased intention to leave (Morrissette and Kisamore, 2020).

2.3.3 The Psychological Contract and the Brand-Experience Gap

The relationship between a nurse and their employer is governed by a psychological contract: an unwritten set of mutual expectations. A psychological contract breach occurs when a nurse perceives that the organization has failed to fulfill its obligations, such as recognizing expertise or providing a supportive environment (Bäckström et al., 2024). As organizations adopt employer branding to attract staff, a gap often emerges between the "external brand promise" and the "internal lived reality" (the brand-experience gap). When the daily experience of high demands and unsupportive leadership contradicts the marketed image, the resulting devaluation leads to turnover (Backhaus and Tikoo, 2004).

2.3.4 Motivation and Self-Determination Theory

Self-determination Theory (SDT) explains human motivation through the fulfillment of three basic psychological needs: autonomy, competence, and relatedness (Deci and Ryan, 2000). Autonomy refers to the experience of having control over one’s work and decisions, competence concerns the ability to perform tasks effectively and develop professional skills, and relatedness reflects the need to feel connected to and supported by others. According to SDT, when these needs are satisfied, individuals are more likely to experience intrinsic motivation, well-being, and work engagement. Conversely, when they are absent or undermined by organizational conditions, motivation and job satisfaction may decline. In healthcare settings, the fulfillment of these psychological needs has been associated with stronger work motivation, greater professional commitment, and lower turnover intentions.

2.3.5 Conservation of Resources Theory

The Conservation of Resources (COR) theory proposes that individuals aim to obtain, maintain, and protect resources that are important for their well-being, such as energy, competence, social support, and a sense of meaning (Hobfoll, 1989). The theory suggests that stress occurs when these resources are threatened or depleted. Furthermore, ongoing resource loss may develop into a loss spiral, where diminishing resources make it increasingly difficult for individuals to cope with demands and recovery effectively.

2.3.6 The Two-Factor Theory

To understand the dual nature of employee satisfaction and dissatisfaction, this study utilizes Herzberg's two-factor theory (Herzberg, 1968). The theory suggests that the factors leading to job satisfaction are entirely distinct from those that lead to dissatisfaction. Herzberg divides workplace elements into two categories: hygiene factors and motivators.

Hygiene factors are extrinsic elements tied to the work environment, such as salary, shift schedules, physical working conditions, and basic administrative policies. While providing adequate hygiene factors does not generate long-term motivation or commitment, their absence or perceived unfairness causes intense dissatisfaction. Conversely, motivators are intrinsic to the work itself. These include recognition, professional autonomy, skill utilization, and the feeling of doing meaningful work (Herzberg, 1968).

Within healthcare research, this framework is particularly useful for separating the drivers of turnover from the drivers of retention. It provides a theoretical basis for understanding how a nurse might experience high intrinsic motivation from patient care, yet still choose to leave an organization due to a failure in basic hygiene factors, such as unsustainable working hours.

2.4 The Swedish Context and Research Fragmentation

Despite the volume of international data, the Swedish healthcare system, characterized by its decentralized, regionally managed structure, presents unique challenges. Previous Swedish research identified that unsatisfying leadership and unsupportive organizations are primary drivers of turnover (Bäckström et al., 2024). However, existing literature remains fragmented:

- The Management-Clinical Gap: Marketing theories like employer branding are rarely integrated with the lived clinical reality of nursing in a Swedish context.

- The Setting Gap: While hospital turnover is well-documented, research on primary healthcare, where nurses manage complex digital triage and coordination, remains limited (Ramstedt Stadin and Cajander, 2024).
- The Process Gap: There is a lack of qualitative research explaining the specific process of how administrative burdens and digital tools impact the work environment of frontline nurses.

Consequently, there is a need for research that synthesizes these fragmented perspectives to understand how organizational conditions and broken promises influence nurse turnover within the specific framework of Swedish primary healthcare.

3. Methodology

3.1 Research Design and Approach

This study adopts an exploratory qualitative research design with an abductive approach. A qualitative design was chosen as it allows for a deep exploration of the subjective experiences and "lived realities" of nurses, which cannot be captured through quantitative metrics alone (Bryman, 2016). The abductive approach was selected to bridge the gap between existing theory and new empirical findings. While a purely inductive approach risks overlooking established organizational frameworks, and a deductive approach can be too restrictive for exploratory data, abduction allows the researcher to move iteratively between the empirical data and theoretical frameworks (Dubois and Gadde, 2002). This approach was particularly useful for this study, as it allowed the findings to be interpreted through the lens of established management and marketing theories while remaining open to unexpected insights from the interviews.

3.2 Data Collection: Semi-Structured Interviews

The primary data for this study consists of 20 semi-structured interviews with registered nurses working in primary care and at hospitals. Semi-structured interviews were chosen because they provide a consistent framework (the interview guide) while allowing flexibility to follow up on interesting or surprising comments made by the participants (Kallio et al., 2016). The guide consisted of three main phases:

- Professional Identity and Motivation: Questions focused on the participant's career "journey" and initial drivers.
- The Lived Work Environment: The JD-R model was directly applied to explore Job Demands (e.g., staffing levels) and job Resources (e.g., professional autonomy and social support).
- Leadership: This block investigated the brand-experience gap by asking participants to compare their initial expectations with their actual daily reality. Leadership was evaluated through questions on feedback loops and psychological safety, i.e., the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk taking, specifically regarding the freedom to voice criticism or ask for help (Edmondson, 1999).

The interviews lasted approximately 45-60 minutes, and were conducted digitally with both researchers present. All interviews were audio-recorded, and transcribed verbatim (word for word) to ensure accurate representation of participants' voices. All interviews were conducted in Swedish and later translated into English for presentation in the thesis.

3.3 Selection of Participants

The study utilized purposive sampling to ensure that the participants had relevant experience within the Swedish healthcare system. Participants were primarily recruited via LinkedIn and personal networks, supplemented by snowball sampling to reach the target sample size. The sample was designed to include nurses with various experiences. To capture a nuanced picture the sample included nurses from both hospitals and PHC. The sample size was pre-determined at 20 interviews, a scope considered sufficient to achieve informational power within the study's timeframe (Malterud et al., 2016). This pre-determined scope was validated during the data collection phase, as thematic saturation was observed toward the final interviews, indicating that no substantially new themes or insights were emerging. Inclusion criteria required participants to be registered nurses currently working in Sweden. This diversity in settings allowed for a comparative analysis of how, and if, organizational factors differ across the different clinical environments. The final sample consisted of 20 nurses (16 female, 4 male) with working experience ranging from 1 to 29 years. Of these, 12 were currently employed in hospital settings and 8 in PHC (see Table 1).

TABLE 1. Description of participants' gender, years of working experience as a nurse and whether they are working at a PHC or hospital.

Pseudonym	Gender	Nurse working experience, years
H1	F	2.5
H2	F	8
H3	M	5
H4	M	4
H5	F	5
H6	F	1
H7	F	9
H8	F	1
H9	F	2
H10	M	11
H11	F	7
H12	F	6
P1	F	5
P2	F	9
P3	F	9
P4	F	25
P5	F	29
P6	F	12
P7	M	4
P8	F	5

H = Nurse working at a Hospital
P = Nurse working at a PHC

The data were analyzed using a thematic analysis, following an abductive approach. The process was iterative, involving a constant movement between the empirical data and theory (Braun and Clarke, 2006). The analysis process was conducted in several stages;

1. Familiarization: Reading through all transcripts to gain an overall sense of the material.
2. Translation: The interviews were translated to English by the researchers.
3. Initial coding: Identifying “meaning units” (segments of text that represent a specific thought or experience).
4. Thematic grouping: Organizing codes into preliminary themes based on their similarities.
5. Theoretical matching: The emerging themes were compared with theoretical frameworks which helps explain *why* certain phenomena occur.

6. Finalizing themes: Defining and naming the final five themes presented in the results.

3.5 Ethical Considerations

This study was conducted in accordance with the ethical guidelines for research involving humans (Vetenskapsrådet, 2017). Key ethical measures included:

- Informed consent: All participants were provided with information about the study's aim and signed a consent form before the interview.
- Anonymity: To protect the identity of the participants, all were assigned pseudonyms such as "H#" and "P#" where "#" is replaced with the participant-number, "H" stands for hospital and "P" stands for primary care. Specific workplace locations have been removed.
- Confidentiality: The interview recordings and transcripts were stored securely and were accessible only to the research team. The recordings were deleted right after being transcribed.
- Voluntary Participation: Participants were informed of their right to withdraw from the study at any time without providing a reason.

3.5.1 GDPR

The empirical data collected and handled have been done according to the information on General Data Protection Regulation (EU General Data Protection Regulation, 2016). With this in consideration, we made sure to only collect relevant and necessary personal data for the paper such as participants, workplace setting, working experience in years and gender. Additionally those who participated in the interviews were informed of the GDPR rules and had to give their consent to participate.

3.6 Trustworthiness

To ensure the credibility and dependability of the findings, the researchers engaged in "peer debriefing", discussing the emerging codes and themes to reach a consensus on the analysis. However, the study aims for transferability, providing "thick descriptions" that may be applicable to similar healthcare contexts across Swedish regions.

4. Findings

This chapter presents the empirical findings from the thematic analysis. To illuminate the lived realities of the profession, the narrative is structured around seven core themes. Throughout the text, participants' experiences are analyzed to bridge the gap between empirical observations and organizational theories.

4.1 Intrinsic motivation

The first theme identified in the interview material regards the primary drivers that led the interviewees to the nursing profession to begin with, and what further sustains their daily commitment. The findings show that the decision to enter nursing is seldom due to a pragmatic or financial consideration. Instead, it is deeply rooted in personal history, a sense of social duty, and the internal emotional rewards gained from patient care. This aligns with the concept of prosocial motivation, defined by Grant (2007) as the desire to work based on a genuine concern for helping others and a belief in the social value of one's work.

4.1.1 The Social Reciprocity

A significant pattern observed among the interviewees is the conceptualization of their career choice as a form of social reciprocity. For several participants, the motivation to become a nurse was a reciprocal response to past encounters with healthcare, either through their own childhood illnesses or by witnessing the care provided to family members. This creates a moral obligation to repay the care once received. This aligns with the norm of reciprocity, where individuals feel a social pressure to return benefits to the system that once supported them (Gouldner, 1960). Furthermore, this highlights a high degree of prosocial motivation, characterized by a desire to invest effort to benefit others and contribute to society through meaningful clinical work (Grant, 2007). Interviewee P7 reflects on this:

> "I was quite sick when I was younger [...] I remember so well how the staff were there, that they were so kind and caring. I got a feeling quite early on that I wanted to give back in some way. That I wanted to work with people in that situation, just as they did for me" (P7).

Similarly, Interviewee H1 described her choice of becoming a nurse as *"self-evident"*, driven by a subconscious need to *"pay back"* to the healthcare system that supported her during a childhood battle with leukemia:

> "Ever since then [being ill with leukemia as a child], I have felt that I want to, like, pay back the healthcare system, that it is something [...] I want to do. Yes, give back all the help I have received." (H1).

This indicates that the psychological contract begins to form for these individuals long before their first day of employment. According to Rousseau and McLean Parks (1993), this represents a relational contract characterized by a high degree of subjective investment. Unlike a transactional contract, where the employee expects a simple exchange of labor for money, these interviewees entered the profession with the expectation that their professional role will align with a personal mission of giving back. This internal narrative creates cognitive consistency where leaving the profession would not merely be a career change, but a contradiction of their core self-concept. This is exemplified by interviewee H4, who contrasts his intrinsic motivation with monetary rewards:

> "It started a bit as a private thing that happened [...] that is why I wanted to become a nurse [...] to be able to give back like I received when I was younger [...] But not the salary. No, not the salary." (H4).

This distinction aligns with Herzberg's two-factor theory, which identifies salary as a hygiene factor rather than a primary motivator (Herzberg, 1968). According to this framework, a fair salary is a necessity that prevents dissatisfaction, yet it does not inherently generate long-term professional motivation or "pull" the individual into the clinical work. Instead, for these interviewees, the primary driver is the intrinsic satisfaction derived from the work itself and the fulfillment of their relational contract. However, as Herzberg assumes, if the salary is later perceived as unfair or unrepresentative of their effort, it becomes a powerful source of dissatisfaction that can undermine even the strongest vocational calling. In this sense, the "payback" the nurses seek is emotional and social, but the organizational failure to provide adequate hygiene factors (salary) can eventually lead to the breach of the very reciprocity they entered the profession to uphold.

4.1.2 The ‘Warm Glow’

When discussing what provides the most professional meaning, the interviewees consistently avoided technical achievements, focusing instead on ‘micro-care’: the small, relational gestures that define their daily practice. This phenomenon aligns with the concept of warm glow, where individuals derive emotional reward and internal utility from the direct act of helping another individual (Andreoni, 1990). Interviewee H1 provides an example of how these micro-interactions sustain her professional identity:

> “...just me placing a hand on the shoulder of a mother who is sad, or fetching a glass of juice or a sandwich for someone who hasn’t eaten for a whole day [...] will change their whole view on why they are there. Just that can make such a huge difference [...] So that is like the main thing, that you know and feel that you are making a difference.” (H1).

According to SDT, these moments satisfy the core psychological need for relatedness (Deci and Ryan, 2000). For the interviewees, the ability to provide micro-care validates their professional identity and satisfies their inherent desire for connection. When this need is met, the work ceases to be merely a series of tasks and becomes something meaningful, directly contributing to long-term retention.

The ability to “make someone’s day” serves as the primary source of clinical flow, representing a state where the nurse’s skills are perfectly aligned with the challenges of care. However, this warm glow is highly fragile within the current Swedish healthcare climate. When analyzed through the JD-R Model (Bakker and Demerouti, 2007), administrative documentation acts as a significant hindrance demand that depletes the time and energy required for meaningful patient interaction. The findings suggest that any capacity recovered from these administrative burdens would be immediately reinvested into clinical care, highlighting a conflict between organizational requirements and professional mission. One interviewee noted:

> “Yes, [I would rather spend that time on] patient encounters, actually.” (P6).

It is precisely within these patient encounters that nurses find the time to perform the relational "little things" that sustain their drive. When one is unable to perform these “little things”, the intrinsic motivation is replaced with moral distress. This psychological strain

occurs when an employee knows the ethically appropriate action to provide high-quality care, but is structurally prevented from doing so by organizational constraints (Jameton, 1984). One nurse explained the exhaustion of knowing a patient was suffering while they were occupied with tasks:

> "I have taken care of 25 patients by myself [...] It becomes difficult to keep track, to manage someone with low oxygen saturation [while] 'little Greta' has broken a finger. Maybe 'Greta' doesn't get as good care as 'Göran' [...] I don't have the hands, feet, or anything to be able to help this patient in the right way, in a reasonable time, in a safe way." (H12).

This testimony highlights a critical imbalance within the JD-R framework. While the nurse carries a strong intrinsic motivation as a resource, the overwhelming job demands (evidenced by the 25:1 patient ratio) surpass her capacity to provide safe care. In this context, the warm glow is structurally extinguished and replaced by moral distress. This suggests that the professional identity is no longer compatible with the organizational reality. Consequently, leaving the organization is interpreted here as a mechanism of self-preservation rather than a withdrawal of professional commitment.

4.1.3 Pragmatic or Accidental Entries

However, the data suggests that this relational entry is not universal, and there are a few outliers to the theme, where a distinct subset of interviewees describes pragmatic or accidental entries. For these interviewees, nursing was a strategic response to external uncertainty or a result of eliminated alternatives. Interviewee H7, for example, entered the profession during the global pandemic, with a need for financial security:

> "I felt that I needed something stable [...]a job with an income [...]it was not like I have dreamt of it for so long." (H7).

Similarly, Interviewee P1 described an accidental entry, choosing nursing only after failing to secure a place in other high school programs: *“I actually thought I would become something else [...] but I didn’t get in and then I just took the chance: ‘No, but I’ll apply for a few nursing programs then”* (P1). These cases illustrate continuance commitment – a state where the bond to the organization or profession is based on the perceived costs of leaving and the lack of viable alternatives (Meyer and Allen, 1991). Unlike the “relational” nurses who have

affective commitment (entering because their values and goals align with the organization), these “pragmatic” entrants are embedded by a transactional contract, where the exchange is primarily labor for security and income (Rodwell and Gulyas, 2013).

However, the empirical evidence indicates that regardless of the initial motivation, the reality of the clinical environment eventually forces a reconciliation with the professional ideal. Interviewee H5 reflects on the erosion of this “ideal nurse” persona:

> "I think many [...] realize after working a few years that the thought they had about [...] helping people, is not really possible to maintain [within the system]" (H5).

For the pragmatic nurse, the absence of an initial warm glow as a psychological resource may make them even more vulnerable to hygiene failures (Herzberg, 1968). If the "stable job" becomes unstable due to high job demands the transactional foundation of the contract collapses. This is exemplified by Interviewee P1 who describes staying not due to professional fulfillment, but due to a sense of being trapped:

> "I have landed in 'What should I do? What should I do?' [...] it feels too difficult to take that step [leaving], so I’d rather stay." (P1).

This suggests that while the “relational” nurse stays for the warm glow and intrinsic motivation, the “pragmatic” nurse may remain due to the lack of agency, which shows that both groups ultimately converge in a state of professional exhaustion when faced with systemic imbalances.

4.1.4 The Double-Edged Sword

Intrinsic motivation is further sustained by the challenge of complex medical cases and specialized competency. Within the framework of SDT, the need for competence serves as a primary pillar of professional satisfaction (Deci and Ryan, 2000). According to the Job Characteristics Model, nurses experience a high degree of task significance, perceiving their daily actions as having a substantial impact on the lives of others (Hackman and Oldham, 1976).

However, this professional efficacy acts as a double-edged sword. While it provides fulfillment, it makes nurses susceptible to overcommitment and "guilt" when organizational factors, such as understaffing, prevent them from meeting their own high moral standards. One interviewee explicitly linked this altruistic drive to organizational failure, noting: “*We*

are quite exploited for our own goodness." (H12). This weight of responsibility is heavy for both specialized and junior nurses. One junior nurse reflected on the sudden gravity of the role:

> "I can get a flash in my head and just [think], 'God, what am I doing?' [...] having children I take care of whose lives lie on my shoulders." (H1).

4.2 Workload, demands and job complexity

The second theme identified through the interviews addresses the demanding and highly complex nature of the profession. Across both settings, interviewees described high workload, staffing shortages, constant coordination, and unpredictable work situations as central aspects of their daily work environment. These experiences demonstrate high job demands, where sustained physical, emotional, and cognitive effort is required over time.

4.2.1 Workload and time pressure

Interviewees across both settings described nursing work as characterized by a continuous high workload, where there is little to no time to rest. Several interviewees described a constant flow of patients and ongoing responsibilities, which made it difficult to find moments to pause. The work was often described as unpredictable and intense, where the pace changed quickly depending on patients' needs. One interviewee explained that *"sometimes you have three patients and two of them are very ill and then you are extremely stressed"* (H1), highlighting how the complexity of care contributed to pressure. Another interviewee explained how *"there are things happening constantly"* (H4), revealing the ongoing pace of the work.

This illustrates that the workload is not only high, but also continuous and difficult to manage, emphasizing the intensity of the work. Such conditions are traits of high job demands, where the pace and volume of tasks require sustained effort over time (Bakker and Demerouti, 2007).

Beyond the immediate intensity of daily work, interviewees also described how this sustained pressure became physically and mentally exhausting over time. Several interviewees emphasized that periods of high pressure often persisted over long periods:

> "We work very long, heavy shifts, often double shifts or very close together. Often I am at work six out of seven days a week" (H12).

> "It [workload] doesn't calm down. It has been high pressure for a very long time, and you get very tired because of that" (H2).

While high workload was described across both hospital and PHC settings, it was experienced in somewhat different ways. In hospital settings, the workload was often described as more acute and task-intensive, driven by patient severity and unpredictable situations. In contrast, interviewees in primary care more often emphasized a high volume of administrative tasks, phone calls, and time pressure related to scheduling and patient flow. One interviewee described how falling behind could create a compounding effect on later tasks:

> "We have around six minutes per call [...] and if we don't keep up, it becomes like a domino effect" (P6).

This suggests that even minor delays could accumulate throughout the day, increasing time pressure and intensifying workload.

4.2.2 Staffing and resources

15 out of the interviewees across both hospital and primary care settings explained that they were often understaffed, and that the number of available staff didn't match their workload. This was described as an ongoing issue, with many participants emphasizing the need for additional personnel. As one interviewee stated:

> "It is quite a tough workplace [...] it wouldn't be wrong to have more hands" (P4).

A direct consequence of staffing shortages was that the present staff had to take on more work. One interviewee described that *"the fewer people we are, the more difficult it becomes [...] there is simply more work for those of us who are there"* (H4). In addition, several interviewees highlighted that staffing levels often remained the same even during periods of increased demand, making it difficult to manage the high workload. One interviewee described:

> "the same staffing [...] is not enough when you are in a busy period [...] it would have been good to have an extra resource" (H9).

Collectively, these statements illustrate how staffing shortages lead to a more intense work situation for those on shift, thereby contributing to the imbalance between demands and available resources (Bakker and Demerouti, 2007).

Interviewees in hospital settings also described limitations in material resources. These constraints were described as adding another layer of difficulty to the work, particularly during busy periods, when many patients needed to be managed simultaneously. Two interviewees explained this clearly:

> "We don't have enough rooms or space or even chairs for everyone who comes in" (H12).

> "...while we sit with duct tape and tape our mattresses in the pediatric emergency room and have had the same type of chairs since the 80s" (H11).

These experiences point to broader structural constraints in the work environment. Together with limited staffing, it further intensifies the mismatch between demands and resources, reinforcing the pressure experienced in everyday practice.

4.2.3 Coordination and the "Spider in the Web" Role

Another important aspect of nursing work is the constant need to manage interruptions and shift priorities, i.e., the cognitive complexity of the work. Interviewees across both settings described frequent interruptions, multitasking, and the need to constantly reprioritize tasks, reflecting high cognitive and psychological job demands (Bakker and Demerouti, 2007). One respondent described how *"the phone rings constantly"* (H2), while another explained:

> "you are constantly interrupted [...] you might not even manage to finish what you started [...] can you call here, can you call there, can you fix this?" (H5).

A recurring pattern through the interviews was that nurses described their role as being the "spider in the web". This expression was used to explain how they are expected to coordinate tasks, manage communication, and ensure that work processes function across different parts of the organization. Several interviewees emphasized that they are often the central person who keeps everything together, handling a wide range of questions and responsibilities. One described:

> "It is basically the nurse's responsibility to coordinate [...] so that everyone gets done what they need to do" (H2).

Others expressed how broad their role can be, where they are expected to *"handle everything [...] questions about pretty much anything"* (P5) and *"have answers to everything"* (H4). In this sense, the role extends beyond direct patient care and includes substantial coordination work.

The interviewees also described being in contact with a wide range of different professional roles throughout the day:

> "You communicate with everyone [...] assistant nurses, doctors, physiotherapists, dietitians [...] even the secretaries" (H7).

Nurses were often responsible for gathering and redistributing information across the team. One nurse explained that they are often the one who *"gets all the information and then has to pass it on as well"* (H9). Together, these experiences illustrate how nursing work involves continuous coordination, communication, and cognitive demands that extend beyond direct patient care. In this sense the "spider in the web" role may also contribute to role overload, as nurses are expected to manage multiple responsibilities, interruptions, and professional interactions simultaneously (Duxbury et al., 2018).

4.2.4 Unpredictability

Unpredictability was also described as a central part of everyday nursing work. In PHC settings this was specifically related to last-minute cancellations and absent staff. Whereas in hospital settings, unpredictability was particularly due to uncertainty regarding patient load and severity of the patients. Nevertheless, both settings involved changing situations during the shift. For example, one nurse explained:

> "It can be calm and then suddenly it becomes acute [...] then you have to shift and reprioritize (H6).

Similar experiences were described across multiple interviews, in which nurses emphasized that they constantly had to reprioritize based on what was happening during the shift. This may increase the cognitive load, as frequent changes require constant attention and shifting between tasks.

Unpredictability was also related to the types of patients and situations that nurses faced during the day. Several interviewees described how the work intensity depended on the severity of the patients, which could vary significantly between shifts. This reflects a high degree of task uncertainty, where the content and demands of the work cannot be predicted in advance (Hackman and Oldham, 1980). As one interviewee explained:

> "You never know what kind of patients you will get when you come to work" (H2).

Throughout the interviews, it also became evident how the workload could fluctuate between days, where some were described as more manageable while others were experienced as significantly more demanding. This highlights how job demands are not constant but change over time, with periods of lower intensity interspersed with more demanding situations.

4.3 Administrative work as a dual experience

Administrative work was described as a significant part of the workday. Nursing work was often described as intense and physically exhausting, involving constant movement and hands-on care, and in this context, administrative tasks could for some provide a brief pause. Several highlighted that it allowed them to sit down, slow the pace, and vary their tasks during the day:

> "It becomes administrative in every visit [...] it may not be that meaningful [...] but you get a moment to breathe [...] you can see it as micro-breaks" (P3).

At the same time, administrative work was often described as time-consuming and less meaningful. Several interviewees expressed frustration and felt that it took too much time away from patient care. This reflects how different tasks are valued differently, where patient-related work is often seen as more meaningful.

In addition, some interviewees felt that administrative work did not make full use of their professional competence, which can be understood as skill underutilization (Feldman, 1996). One interviewee explained this as:

> "It's not necessarily a nurse who needs to take that call [...] but it's still us who end up doing it" (P1).

This may also relate to unmet needs for competence, which according to SDT can reduce intrinsic motivation (Deci and Ryan, 2000).

4.4 Emotional and psychological demands

Another recurring theme in the interviews concerned the emotional and psychological demands embedded in nursing work. Interviewees described emotional strain related to patient interactions, responsibility and exposure to suffering.

4.4.1 Emotional Labor

Several interviewees explained that they are expected to remain calm, empathetic and professional in all interactions with patients and relatives, regardless of their own emotional state. One interviewee explained:

> "a patient is going through the most traumatic thing one can experience, and that is just one of my work tasks" (H1).

This highlights how nurses are expected to show empathy and emotional support even in situations that are routine parts of their everyday work. Interviewees also described how they needed to manage and suppress their own feelings in order to maintain a professional approach towards patients, even during personally stressful or emotionally demanding days. These experiences can be understood as emotional labor, where individuals regulate their emotions in order to meet organizational and professional expectations, reflecting what Grandey (2000) describes as surface acting. Because this involves managing a discrepancy between felt and expressed emotions, repeated emotional regulation may increase the risk of emotional exhaustion over time, particularly when recovery is insufficient.

4.4.2 Exposure to patients and relatives

A vast majority of the interviewees working in hospital settings described how their work involves regular exposure to difficult and, at times, traumatic situations. One interviewee referred to *"very traumatic experiences [...] from anything to death"* (H4), while another described the severity of cases by explaining that *"there are very sick children who come here [...] there can be very [emotionally] heavy patients"* (H5). This illustrates how nurses are repeatedly exposed to difficult situations and patients' suffering. Such repeated exposure may contribute to compassion fatigue, where ongoing contact with suffering becomes emotionally draining (Figley, 1995). Furthermore, navigating interactions with distressed relatives adds a distinct layer of emotional demands to everyday nursing work.

Interactions with relatives were often characterized by strong emotional reactions such as grief, worry or distress. The interviewees emphasized how relatives contribute to an already demanding work environment, with one noting that: *"relatives can also be part of creating a stressful everyday situation"* (H9). Others described more intense situations involving family members in crisis:

> "[the] parents [...] lying on the floor and screaming for their child" (H11).

This can be understood as part of the emotional demands of the work, where managing others' emotions becomes an additional layer of strain.

4.4.3 Responsibility and Risk

Responsibility emerged as another central aspect of the work, which many interviewees experienced as both demanding and, at times, intimidating. This was especially common in hospital settings involving more matters of life and death. Several highlighted that their actions could have serious consequences, including risks to patient safety, which adds pressure to everyday work. One interviewee expressed the seriousness of this responsibility clearly:

> "I could actually kill someone [...] if I make a mistake" (H12).

Another one expressed how overwhelming this responsibility could feel:

> "Now I realize how much responsibility I have [...] how much is actually expected of me [...] it is very scary to have so much responsibility" (H6).

This shows that nursing responsibility is extensive and that mistakes can have serious consequences, which contributes to feelings of fear and pressure. This can be understood as a significant job demand, which may create psychological strain over time (Bakker and Demerouti, 2007).

4.5 Social support as a buffering resource

A central finding across the interviews was the role of social support from colleagues, acting as a primary job resource that protects employees from the negative effect of high job demands (Bakker and Demerouti, 2007). While leadership was at times perceived as distant or transactional, the horizontal relationship between peers emerged as a source of stability.

Teamwork was described as essential by all participants, who highlighted a culture where colleagues eagerly *"step in"* (H1) and the entire team *"comes together"* (H4) to resolve clinical crises through constant communication.

This collegial support is not just practical, but it also creates a sense of psychological safety that is normalized within the work environment (Edmondson, 1999). According to social exchange theory, the reciprocal nature of helping creates a safety net based on mutual dependency (Blau, 1964). One nurse stated: *"I always support my colleagues and I feel that they always support me"* (H11), while another noted that: *"it's accepted in the unit to ask for help"* (H12). By normalizing the act of seeking assistance, the team reduces the weight of individual responsibility and mitigates the stress associated with potential errors.

4.5.1 Emotional Buffering and Professional Sustainability

While the previous section outlines the practical safety net of teamwork, social support also serves as a deeper emotional resource necessary for long-term sustainability. Interviewees described a high degree of emotional labor sharing, where they process the trauma and moral distress of the clinical floor together (Hochschild, 1983). This collective coping is a key factor in maintaining the energy needed to stay in the profession, as one interviewee reflected:

> "...sometimes [we] just sit and cry together or sit and laugh [...] If we didn't have each other [...] Then I don't think we would have the energy to keep going." (H12).

This collegial bond acts as an energy-reloading resource that prevents the complete exhaustion of the nurse's personal reserves when organizational resources, such as staffing or management support, are lacking (Bakker and Demerouti, 2007). This leads to a strong sense of affective commitment, where the emotional attachment to the team becomes the primary reason for staying at the workplace (Meyer and Allen, 1991). As one nurse noted: *"the colleagues are a big part of why I actually want to stay here"* (P7).

4.6 Leadership

The following section examines the role of leadership and managerial support as decisive factors in the nurse's work environment. The findings reveal tensions between higher-level

management and everyday clinical work, where decisions made at organizational levels often were experienced as disconnected from the realities of daily nursing practice.

4.6.1 Leadership at the organizational level

Across the interviews, there was a clear and consistent dissatisfaction with higher-level management, particularly because nurses felt excluded from decision-making. Several interviewees described how their perspectives were not taken into account, even though decisions directly affected their daily work, which often was experienced as frustrating. One interviewee said:

> "you tell them [higher management], but then you never hear what came out of it" (P1).

Others expressed similar experiences, describing how decisions were made without their input, or that they were sometimes *"silenced"* (H7) and not fully included in discussions. These experiences can be related to a lack of participative leadership, where employees have limited influence in decision-making processes (Vroom and Yetton, 1973).

In addition to not being involved in decisions, they also felt that higher-level management lacked understanding of their daily work. Decisions were often described as being made far from practice without enough understanding of nurses' daily work, which created frustration. One interviewee illustrated:

> "decisions are often made three, four levels above [...] so high up that they don't even see what consequences the decisions actually have" (H2).

Similar views were expressed by several interviewees, reflecting a top-down approach where there is a disconnect between organizational levels.

4.6.2 Local leadership

In contrast to higher-level management, experiences of local leadership varied across the interviews. Many described their closest managers as present, accessible and actively involved in the daily work. In these cases, leadership was experienced as supportive and it contributed to a positive work environment, where communication was open and collaboration was encouraged. Interviewees often described managers with a background in

nursing as better able to understand the work and provide relevant support. As one interviewee explained:

> "She is a nurse herself [...] which makes it easier. Because she understands our work [...] you get much better support from her because she understands what we do" (P1).

Others described that managers who were present in daily work, for example by being out on the floor, contributed to a sense of closeness and trust. Overall, these experiences illustrate how accessible and engaged leadership can function as a resource in everyday work, supporting both collaboration and well-being (Bakker and Demerouti, 2007). These experiences can be related to Leader-Member Exchange (LMX) theory, where close and supportive relationships between leaders and employees facilitate trust and support (Graen and Uhl-Bien, 1995), and may also contribute to psychological safety where employees feel comfortable raising concerns (Edmondson, 1999).

At the same time, some interviewees felt that their local managers were distant from daily work and lacked the understanding of staff needs. As one interview described: *"The managers are mostly in their offices and not out and watching what we are doing on the floor"* (H8). Leadership was also at times perceived as lacking both openness and understanding with one interviewee describing how their manager had a direct impact on their decision to leave the workplace:

> "the reason I actually chose to change workplace [...] was that we got a new manager [...] she was absent [...] don't listen [...] not open [...] she had the attitude that she knew better even though she has never worked in our unit [...] many chose to leave the workplace" (H12).

These experiences suggest that when managers are not present, accessible or familiar with the work, leadership can instead become a source of strain. Local leadership therefore appeared to play a central role in shaping the work environment, and may significantly influence nurses' decisions to remain at or leave a workplace.

4.6.3 Opportunities for development and specialization

Opportunities for development and specialization were described as important aspects of leadership. Several interviewees highlighted that their managers encouraged them to develop

their skills, and in some cases also supported this through funded education or opportunities for specialization.

> "Right now I'm actually studying to be a district nurse too, part-time then via the job [...] I get to keep my salary while I study" (P3).

This can be related to the need for competence described in SDT, where opportunities to learn and develop may strengthen extrinsic motivation and contribute to a more positive experience of work (Deci and Ryan, 2000).

4.6.4 Recognition & Feedback

Several interviewees described receiving limited feedback from their closest managers and that it was mainly given when something had gone wrong. As described by one participant: *"it is very rare that you get feedback [...] you also want to hear when things are going well"* (P1). The lack of recognition contributed to a feeling of not being seen or valued in their role, and was also described as affecting motivation: *"when the manager doesn't really acknowledge us [...] it doesn't really increase motivation"* (P3). This suggests that feedback and recognition are important aspects of leadership, where a lack of acknowledgement may negatively influence motivation and the overall experience of work.

Issues related to recognition in terms of how their work and experiences were valued was also raised and this was particularly evident in discussions about salary. One interviewee said:

> "It is very frustrating when newly graduated nurses are hired with a higher salary than you" (H4).

Such experiences were described as affecting how valued they felt in their roles, and in some cases it contributed to dissatisfaction. This shows how recognition is not only expressed through feedback, but also through organizational practices such as compensation, which can influence both motivation and perception of fairness.

4.7 Recovery & sustainability of work

Recovery also emerged as a crucial theme throughout the interviewees, particularly in relation to the high workload and emotional demands of nursing work. Limited opportunities for recovery were frequently described, both during and after the workday.

4.7.1 Limited recovery during the workday

Breaks during the workday were often skipped due to high workload and interruptions, and even when they had breaks, these were not experienced as actual rest but rather as rushed and embedded within work. One explained:

> "We don't really have 30 minutes where we can be left in peace [...] you eat your food and then you run off [...] it's not a calm half hour you get" (H2).

This illustrates how even short breaks during the workday may fail to provide sufficient recovery.

The overall intensity of the work was also described as limiting recovery throughout the shift. The work was characterized by a *"constant inflow of tasks"* (H3), frequent interruptions, and a feeling of *"never being finished"*(H3), which leaves little opportunity to mentally pause. One interviewee explained:

> "Eight hours and all you do is meet person after person [...] you get tired in your head [...] you start mixing up what you've said" (H12).

Taken together, this illustrates how recovery is limited, not only due to the absence of breaks, but also by the continuous and fragmented nature of the work itself. The constant interruptions and shifting demands may require continuous mental effort and reorientation, thereby limiting opportunities for mental recovery.

4.7.2 Limited recovery after work

Several interviewees also described difficulties in mentally detaching from work when the workday was over. Thoughts about work often continued into non-work time, particularly in the form of rumination, such as reflecting on whether something had been forgotten or not handled correctly. One interviewee explained:

> "When I get home [...] you go through almost everything [...] did I do this [...] did I write that [...] did I visit that patient [...] you have so much going on in your head [...] sometimes it's hard to really let go" (H12).

These experiences suggest that mental disengagement from work is limited, reflecting impaired psychological detachment, which is defined as the ability to mentally disconnect

from work during non-work time. According to Sonnentag and Fritz (2007), this is considered a key mechanism for recovery from work-related stress. From an effort-recovery perspective, recovery becomes incomplete when stress-related activation continues during non work-time (Meijman and Mulder, 1998). When this continues over time, fatigue may accumulate and contribute to allostatic load, where the body's stress regulation systems fail to fully return to baseline (McEwen, 1998). Insufficient recovery may then affect not only nurses' well-being, but also their ability to provide sustainable and high-quality patient care.

The ability to detach from work was also described as varying depending on the situation. They highlighted that emotionally demanding situations, particularly involving very ill patients, made it more difficult to disconnect after work:

> "If you've had a very sick patient, it can take some time before you can switch off" (H5).

Others emphasized how thoughts about responsibility or uncertainty could prolong this process:

> "If I feel like I've done a good job, then I can quite easily switch off [...] but if something feels off [...] then I have a hard time letting it go when I get home" (H6).

Being contacted after working hours or continuing to think about patients and ongoing cases were also described as factors that made it more difficult to detach:

> "you can come home from work and just wonder if it went well [...] you don't really let go [...] it's easy to message a colleague [...] how is it going with that patient [...] sometimes colleagues contact me even if I am not working [...] I personally find it a bit hard to let go" (H8).

Interviewees working in primary care more often described being able to mentally disconnect after work, whereas those working in hospital settings more frequently reported difficulties in letting go of work-related thoughts. This difference appeared to be related to the nature of the work, where hospital nurses worked varying shifts and handled more acute situations.

4.7.3 The role experience plays in recovering

At the same time, it was commonly described in the interviews that their ability to mentally detach from work had developed over time. While detachment was experienced as difficult

when they first started working within the profession, more experienced nurses described that they had become better at “letting go” after work. One reflected on this development:

> “In the beginning [...] it was very difficult [letting go] [...] then after a few years [...] you find your way [...] you get better at it” (H4).

This reflects that coping strategies developed through experience, where individuals have learned ways to manage work-related thoughts and psychologically disengage after work. In this sense, experience can be seen as a personal resource that supports psychological detachment after work.

4.8 Horizontal turnover

A common pattern across the interviews is that nurses rarely express a desire to leave the nursing profession entirely. Rather, they seek to escape specific organizations but within the profession. This empirical occurrence is classified as horizontal turnover - a process where employees change units, workplaces, or clinical settings rather than exiting the profession.

Previous studies on horizontal turnover emphasize that this mobility often acts as a self-preservation mechanism; when job demands exceed available resources, nurses systematically move toward organizational settings that offer better working conditions, even if their commitment to the nursing profession remains high (Pyhäjärvi and Söderberg, 2024). In the gathered data, this horizontal mobility is exclusively directed away from high-acuity hospitals and towards PHC.

4.8.1 Escaping the “three-shift” and unpredictable load

The primary catalyst for horizontal turnover among the nurses who had moved from working at a hospital to PHC, was the physical and mental exhaustion associated with 24/7 hospital work. Participants frequently described the three-shift system and unpredictable patient loads as unsustainable demands that erode recovery time. Interviewee P6, who transitioned to a PHC after years in hospital settings, explained the relief of this environmental shift:

> “Now is the first time I don't work evenings and weekends [...] You don't have that high pressure for such a long time [...] You're not as physically exhausted when the vacation finally comes”(P6).

Similarly, interviewee P1 said that leaving the hospital setting was a fundamental necessity for her personal health:

> “I left the hospital because of the working hours and the high workload. I sought a daytime job to get a functioning life [...] It’s a huge difference to 'get a life' back”(P1).

In these accounts, the lack of basic organizational stability, specifically predictable hours and manageable workloads, acts as a decisive “push” factor to leave. According to Herzberg’s (1968) two-factor theory, chronic understaffing and demanding shift systems reflect deficiencies in important hygiene factors related to working conditions. The data shows that no amount of intrinsic motivation can compensate for the failure of these basic working conditions, prompting nurses to initiate horizontal turnover toward more sustainable environments.

4.8.2 Moving Towards Autonomy

When transitioning horizontally, the move was often from acute hospital settings toward PHC or specialized units. Those environments offer a critical shift from managing massive, unpredictable patient flows to providing planned care. Interviewee H5, who recently transitioned from acute pediatric inpatient care to a specialized unit at the hospital, described this factual shift in her daily work:

> “I have just switched so that I work at a clinic [...] now it's much more about having patient contact, but then it's not emergency care but rather planned visits [...] I felt before if I should just do something else entirely because it was so burdensome” (H5).

A crucial driver for moving specifically toward primary care is the perceived increase in professional autonomy. While hospital settings are often characterized by steep hierarchies, PHC places the nurse in the role of the primary assessor. Interviewee P1 noted this shift in professional responsibility:

> “I experience a greater responsibility in assessments of acute patients compared to a ward... It is up to me to judge if it is acute or not. There I really get to use my competence”(P1).

Interviewee P7 mirrored this, explaining why he never considered leaving the profession, but only changing the environment:

> "I've never wanted to leave the profession itself... but I'm thankful that I work at a primary care clinic and not a hospital where the stress is higher" (P7).

Viewed through SDT (Deci and Ryan, 2000), horizontal turnover allows nurses to secure a high-resource environment where their core psychological needs for autonomy and competence utilization are met. From a JD-R perspective (Bakker and Demerouti, 2007), this confirms that nurses actively migrate toward organizations that offer structural resources to counterbalance the inherent demands of patient care.

5. Discussion

5.1 Organizational conditions and the sustainability of nursing work

The findings can be understood through the JD-R model, which suggests that high workload in itself is not necessarily harmful, but when these demands are not matched with sufficient resources, this may create an imbalance that increases the risk of strain over time. Research within the JD-R framework emphasizes that certain demands can be manageable and even motivating when sufficient resources are available to support them, because this combination allows employees to learn, take responsibility and experience a sense of accomplishment (Bakker and Demerouti, 2007). The problem occurs when demands become too high in relation to the available resources and when nurses no longer feel capable of providing the kind of care that they believe patients deserve. Over time, this imbalance makes meaningful care increasingly difficult to sustain.

This imbalance can also be understood through the DISC-R framework (De Jonge and Dormann, 2006). In the findings, social support clearly functioned as an important emotional resource. Even though this peer support seemed to buffer some of the emotional strain connected to working with severely ill patients, distressed relatives and high responsibility, it cannot act as a compensation for organizational failure. The findings highlighted how the quality of local leadership had a massive influence on their decisions to stay or leave their workplace. Supportive and present leaders contributed to a collaborative and sustainable workplace, whereas absent leadership instead seemed to contribute to frustration and organizational detachment. This indicates that leadership can either buffer or intensify job demands depending on how it is exercised.

The profession also involved substantial task-related and cognitive demands that were not matched by equivalent organizational resources. Interviewees frequently described constant interruptions, understaffing, unpredictability and coordination responsibilities, while also explaining that they often did not have time to take proper lunch breaks or mentally pause between tasks. This suggests that workload regularly exceeded the available time and staffing resources, limiting opportunities for recovery. The health impairment process within the JD-R framework helps explain the potential consequences of this imbalance, as prolonged exposure to high demands, particularly when resources and recovery opportunities are insufficient, gradually increases the risk of fatigue and emotional exhaustion (Bakker and Demerouti, 2007).

The combination of substantially high demands and poor organizational structures generate a work environment where nurses are not able to provide the level of care that they believe the patients deserve, resulting in feelings of guilt and frustration. This reflects moral distress, where nurses are prevented from acting according to their ethical and professional values due to organizational constraints. Several interviewees also described patient interactions as one of the most meaningful aspects of the profession, but emphasized that high workload and organizational demands took time away from this part. Over time, chronic moral distress may intensify as workers experience a growing conflict between the moral purpose of their profession and the realities imposed by the system (Jameton, 1984). This suggests that the problem was not only that the work was demanding, but that the organizational structures made it difficult to perform the work in accordance with the moral purpose of the profession.

Although public discourse conceptualizes nursing with a strong sense of calling, the findings suggest that this professional commitment functions as a resource that can gradually become depleted under constant organizational strain. This dynamic can be understood through the COR theory (Hobfoll, 1989), which indicates that individuals aim to protect, maintain and build valuable resources that are crucial for their well-being, such as the sense of meaning derived from being able to provide effective and meaningful patient care. However, when severe organizational strain and administrative demands consistently interfere with this, the elements of the work that previously protected against the demands are eliminated, ultimately extinguishing warm glow. When resources such as energy, meaning or efficacy diminish faster than they can be restored the nurse enters a so-called COR “loss spiral”, where ongoing resource depletion gradually makes recovery and coping more difficult. Over time, this may

shift the internal narrative from “I am exhausted but helping” to “I’m exhausted and prevented from helping”.

Given these substantially high demands, recovery becomes critical. Interviewees in hospital environments frequently described difficulties in detaching mentally from work, particularly due to acute patients, shift work and emotionally intense situations. When work-related thoughts and emotional demands continue into non-work time, the boundary between work and home becomes increasingly blurred, creating a form of work-home conflict that may limit psychological recovery and increase the risk of fatigue over time. In contrast, nurses in primary care described more clear boundaries between work and private life and experienced better recovery. This can be understood through border theory, which emphasizes that work and home fulfill different psychological functions and that recovery requires some degree of separation between these domains (Clark, 2000).

The ability to mentally detach from work appeared to improve with experience, as many nurses developed coping strategies and stronger emotional boundaries over time. Experience therefore functioned as a personal resource that helped nurses manage the emotional demands of the profession (Bakker and Demerouti, 2007). However, these coping strategies risk normalizing structurally unsustainable working conditions, where recovery becomes a learned survival strategy rather than an organizational responsibility. A sustainable healthcare system cannot depend on employees gradually learning how to tolerate chronic understaffing, constant interruptions and emotional overload.

5.2 Horizontal turnover as organizational detachment rather than professional withdrawal

When organizational demands consistently weaken the ability to recover, nurses respond not by abandoning the profession but by detaching from the specific organization. This behavioral outcome is heavily driven by a psychological contract breach. The findings indicate that most nurses enter the field with a relational contract rooted in meaning, social reciprocity, and professional contribution rather than a purely transactional one focused on salary or career progression. For these individuals, work is expected to provide more than just employment. It is expected to offer a platform for recognition and the possibility to practice care in line with professional values.

Dissatisfaction becomes emotionally significant because organizational shortcomings are experienced as a fundamental breakdown in reciprocity between the nurse and the organization (Rousseau and McLean Parks, 1993). A primary driver of this breach is the prevalence of administrative tasks over clinical nursing. As stated in 4.3, this creates a state of skill underutilization which, through the lens of SDT, frustrates the core psychological need for competence. When expertise is sidelined by bureaucracy, the nurse's professional identity is effectively devalued.

This devaluation signals to the nurse that their clinical expertise is not respected by the employer, leading to a state of Effort-Reward Imbalance (ERI). Stress peaks when massive emotional and cognitive effort is not met with fair financial or organizational rewards. The ERI framework helps explain why unfair salary structures become a profound source of frustration even when salary is not the primary motivation for entering the profession (Siegrist, 1996). Rather than functioning solely as economic compensation, salary acts as a symbolic form of recognition. When years of responsibility and emotional investment are not reflected in compensation, it is interpreted as a sign that the organization does not value the nurse's expertise. As stated in 4.1.1 salary functions as a hygiene factor. While it may not create intrinsic motivation, its perceived unfairness triggers intense dissatisfaction and a sense that the relational contract has been violated (Herzberg, 1968).

Consequently, a deviation occurs where nurses maintain high occupational commitment and a love for nursing but develop a profound lack of organizational commitment and a rejection of the employer. This creates a brand-experience gap where the internal reality of the clinical environment contradicts the Employer Value Proposition (EVP) of a supportive, professional workplace (Backhaus and Tikoo, 2004). In response, horizontal turnover becomes a strategic mechanism of self-preservation. The migration between organizations is not a withdrawal from nursing, instead, it is a search for a sustainable organizational fit in an environment where structural autonomy and predictability allow the nurse to recover and practice care according to their professional ideals.

5.3 Public crisis narratives versus lived professional meaning

5.3.1 Public portrayals and lived professional reality

The findings challenge the established public portrayals of nursing, which frames it as a profession characterized by burnout and strong dissatisfaction. Although several interviewees described significant strain and organizational pressure, their narratives simultaneously displayed meaning, professional pride and strong engagement to patient care. This reveals a more multifaceted reality than the one that is commonly communicated in public media about the profession. To a large extent, the public image of nursing is heavily shaped through crisis narratives, whereas the first-hand professional experience expressed by the interviewees was considerably more nuanced.

This becomes particularly interesting in relation to the "loyal-but-leaving" paradox, as nurses maintain strong occupational commitment while distancing themselves from specific organizations. The findings indicate that dissatisfaction was primarily connected to organizational structures and working conditions rather than to nursing as a profession itself. This suggests that turnover is not necessarily about wanting to leave nursing, but rather about trying to find conditions where meaningful care is still possible. This further reinforces the pattern of horizontal turnover identified throughout the study.

5.3.2 Crisis narratives, employer branding and organizational turnover

One interesting aspect emerging from the interviews concerns employer branding and organizational reputation. From this perspective, how healthcare organizations are portrayed externally becomes particularly important, since workplaces are shaped not only by employees' own experiences, but also by media and public discourse. The findings indicate that organizations may not fully control their own employer brand, as public narratives emphasize crisis, burnout and dissatisfaction also influence how workplaces are perceived. Persistent crisis narratives may therefore weaken the organization's EVP, meaning the perceived value and attractiveness associated with working there.

Although recruitment was not examined directly in this study, the findings raise important questions regarding long-term consequences of persistent crisis discourse. Interestingly, one interviewee described how repeated negative media reporting and scandals surrounding the workplace contributed to thoughts about leaving that specific organization. Although this was

not a dominant theme across the interviews, it raises interesting questions about how workplaces are perceived. If nursing continues to be publicly framed primarily through exhaustion and organizational failure, this may eventually influence the attractiveness of healthcare employers and contribute to future recruitment challenges within the healthcare sector.

5.4 Overall interpretation

Combining these insights reveals that high turnover among nurses is not primarily driven by a loss of commitment to the profession. In fact, nurses expressed strong professional pride and a persistent desire to deliver meaningful patient care. Rather, turnover appeared to stem from broken organizational conditions that obstruct nursing work from being sustainable over time. High workload in itself was not necessarily considered undesirable, but when combined with insufficient staffing, limited recovery opportunities and organizational constraints restraining nurses from providing meaningful care, the work became both emotionally and physically unsustainable. In an attempt to escape these environments, nurses often moved horizontally, i.e., they left their specific workplace rather than complete professional withdrawal, due to their strong willingness in providing patient care. While the media portrays the current nursing crisis as a mass exodus from the profession, these findings suggest the reality is a breakdown of organizational stability. The crisis is not a loss of professional commitment but a failure of workplace conditions that prevents nurses from practicing sustainably. Instead of leaving the profession, nurses move horizontally to find environments that align with their values.

5.5 Limitations

To ensure the trustworthiness and transparency of this study, several limitations must be acknowledged:

Gender imbalance: The sample consisted predominantly of women. While this largely reflects the natural gender distribution within the Swedish nursing profession, the specific workplace experiences and coping mechanisms of male nurses may be underrepresented.

Network and snowball sampling: Relying on social networks for recruitment may have influenced how participants framed their experiences due to social proximity. However, in

qualitative research, this also serves as a strength, granting the researchers deeper trust, openness, and access to emotionally demanding topics that might otherwise remain hidden.

Cross-sectional design: The study captures the participants' experiences at a single point in time. Because burnout, recovery, and turnover intentions fluctuate and evolve, longitudinal research would be required to understand how these attitudes develop over an entire career lifecycle.

Contextual boundaries: The findings are heavily situated within the decentralized Swedish healthcare model. Consequently, these organizational dynamics may not fully translate to healthcare systems organized or funded differently.

Translation and interpretation: Translating the interview excerpts from Swedish to English may have subtly altered certain linguistic nuances or emotional expressions. Furthermore, qualitative analysis is inherently interpretive; while peer debriefing was utilized to ensure analytical consistency, researcher subjectivity remains a factor.

Despite these limitations, this study contributes meaningfully to the field of healthcare management. By integrating management theories (such as Employer Branding and the JD-R model) with the lived clinical reality of nursing, and by providing a comparative lens between hospitals and primary care, this study provides a comprehensive and nuanced analysis of the turnover process. It successfully moves the conversation beyond generalized burnout, providing qualitative insight into exactly why and how organizational failures drive horizontal turnover.

5.6 Implications

5.6.1 Managerial implications

Based on the findings, several managerial implications can be identified to improve nurse retention and organizational sustainability.

Firstly, healthcare managers should prioritize operational presence and visibility on the clinical floor. The study highlights that scrub-wearing local managers who participate in daily clinical tasks to release strain on the personnel foster significantly higher levels of trust and psychological safety. By reducing the perceived distance between management and

operational work, leaders can better understand clinical constraints and provide more effective support during high-pressure periods.

Secondly, organizations should adopt a more nuanced approach to job design that balances clinical demands with opportunities for professional growth. The high value placed on funded specialist education and internal responsibility roles suggests that investing in human capital is a strong retention tool. Managers should view professional development not only as a cost, but as a strategic investment that builds organizational loyalty and cancels out dissatisfaction with salary or working hours.

Thirdly, there is a clear need for improved vertical communication regarding organizational decision-making. Managers should involve nurses in the early stages of implementing new systems or other big changes to prevent the moral distress that occurs when a nurse's expert competence is underutilized. Providing timely feedback and clear rationales for decisions can help bridge the gap between "on-floor" realities and higher-level administrative mandates.

Finally, retention efforts should focus on creating a sustainable working rhythm that protects recovery. This includes strictly sticking to scheduled breaks and ensuring that staffing levels are flexible enough to absorb predictable spikes in patient inflow. Even though professional commitment seems to be a finite resource, management can not rely on individual coping strategies and should instead focus on structural solutions that can ensure long-term health and motivation.

5.6.2 Implications for future research

Since this study mainly explored turnover intentions, employee well-being and organizational experiences from the perspective of operational nurses, future research could adopt a more top-down perspective by examining these issues from the lens of higher management and organizational level leadership. A recurring pattern throughout the study was that interviewees perceived a distance between the “on-floor” work and organizational decision-making, therefore it would be relevant to further explore what structural, financial or organizational constraints that actually influence management decisions within healthcare organizations.

Future research could also compare differences between state-owned and private healthcare settings in the context of leadership, workload, organizational support and turnover patterns.

Additionally, the findings reveal that experience may have an influence on how nurses manage emotional demands, recovery and long-term sustainability within the profession. This provides an opening to examine how newly educated and more experienced nurses deviate in their experiences of organizational conditions, coping strategies and turnover intention.

6. Conclusion

RQ1: How do organizational factors influence nurses' attitudes and turnover-related behavior, and how do these experiences differ between hospital and primary healthcare settings?

The findings reveal that dissatisfaction was not connected to nursing as the profession itself, but rather to the organizational conditions that shape daily work. Despite high workload, stress, understaffing and frustration towards higher management, nurses remained strongly motivated by patient care and the meaningfulness of the profession. However, distinct weaknesses in organizational structure contributed to the willingness of leaving the workplace.

The specific nature of these structural shortcomings varies significantly depending on the clinical setting. Hospital nurses were most affected by physical exhaustion related to shift work, acute situations, and limited recovery after work. Whereas, nurses in primary healthcare instead experienced more cognitive strain connected to substantial amounts of administrative work. Yet, regardless of the setting, both environments delivered the same adverse outcome: high work-related demands consistently reduced the time available for meaningful patient contact. When structural barriers interfered with the relational care that initially attracted them to the profession, nurses experienced intense moral distress rather than a loss of their calling-driven motivation.

Leadership and employer branding also influenced how nurses viewed their workplace, particularly when there was a gap between how organizations presented themselves and the reality nurses faced in practice. Overall, turnover-related behavior was closely connected to whether organizational conditions allowed nurses to perform meaningful and sustainable nursing work.

RQ2: Why do nurses ultimately decide to stay within or leave their job or the nursing profession?

The decision to stay within or leave a workplace is fundamentally driven by a nurse's need to protect their professional calling and personal well-being. Nurses primarily stay in demanding environments due to two factors: high intrinsic motivation (specifically the warm glow derived from patient care) and strong collegial bonds (social support). When organizational structures fail to provide adequate resources, collegial support acts as a survival buffer. Consequently, nurses often develop a strong affective commitment to their team rather than their local manager, meaning they remain on the floor out of a sense of duty to their colleagues and patients rather than loyalty to the organization.

When nurses decide to leave their job, the findings reveal that it is rarely a rejection of the nursing profession itself. Instead, it is a localized self-preservation mechanism triggered by hygiene failures and moral distress. When systemic constraints and absent leadership consistently obstruct nurses from fulfilling their professional duties, it triggers an erosion of their professional commitment, eventually leading to emotional exhaustion. To survive this, they initiate horizontal turnover, a strategic migration to a different organizational environment. This mobility takes multiple forms, whether it involves transitioning away from high-acuity hospitals toward PHC, or moving laterally between different hospitals and PHC centers in search of a sustainable fit. Nurses make these transitions to reclaim professional autonomy and the structural resources necessary to continue practicing care sustainably and meaningfully.

Ultimately, nurses leave the nursing profession entirely only as an absolute last resort. While extrinsic factors such as salary are significant, they rarely serve as the primary motivation for remaining in the field. Instead, intrinsic motivation, rooted in the desire to help others and the sense of meaning derived from patient care, acts as the fundamental driver that sustains nurses when organizational structures fail to provide reasonable working conditions.

When job demands consistently exceed available resources, it is this internal commitment to the vocation that pushes nurses to continue. However, when the imbalance between demands and resources directly impairs their professional capabilities and their ability to provide meaningful care, even this intrinsic motivation begins to erode. This final departure occurs when the psychological contract is irreparably broken and the moral injury sustained from continuous organizational failures outweighs the intrinsic rewards of the profession. Therefore, leaving nursing is not a sudden loss of passion, but the final consequence of a

healthcare system that relies on individual resilience rather than building structurally sustainable work environments.

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8. Appendix

8.1 The Interview Guide

Introduktion

1. Kan du berätta lite om din resa till att bli sjuksköterska? Varför valde du yrket från början?
2. Hur länge har du jobbat som sjuksköterska?
3. Har din inställning till jobbet förändrats under tiden? Vad kan det bero på?
4. Vad är det som motiverar dig att fortsätta arbeta som sjuksköterska?
    a. Utveckling, lönen, passar det med dina egna värderingar?
5. Har du någon gång övervägt att byta arbetsplats eller lämna yrket? Kan du berätta vad som fick dig att tänka så?
6. Vad är det som får dig att stanna kvar idag?
7. Har du arbetat (som sjuksköterska) på någon annan arbetsplats? Om ja, finns det några skillnader från där du arbetar idag? Om du vill utveckla, var det någon specifik anledning till att du bytte?

Arbetsmiljö

8. Kan du beskriva hur en vanlig jobbvecka ser ut för dig? (Vilken avdelning jobbar du på)
    a. Vad har du för typiska dagliga arbetsuppgifter?
    b. Vilka delar av det är det du tycker är mest krävande?
9. Hur länge har du arbetat på denna arbetsplats?
    a. När du först började arbeta på din nuvarande arbetsplats, vad hade du för förväntningar om hur det skulle vara?
    b. Hur skulle du säga att förväntningarna står sig i jämförelse med din faktiska dagliga upplevelse nu? Finns det vissa saker där förväntningarna inte stämde överens med verkligheten?
    c. Var skulle du säga att dina förväntningar kom från? Kanske från något någon annan sagt, tidigare erfarenheter, jobbannonsen, osv
    d. Om någon annan sjuksköterska frågade dig varför de skulle arbeta på din arbetsplats istället för någon annan, vad hade du sagt till dem då?
10. Har dina arbetsuppgifter ändrats något sedan du började?
11. Skulle du anse att det jobbet du gör dagligen känns meningsfullt för dig personligen?
12. Vilka delar tycker du känns mest meningsfulla för dig personligen när det kommer till de arbetsuppgifterna du gör dagligen?
13. Finns det några arbetsuppgifter som du tycker känns mindre meningsfulla?
14. Vad skulle du säga är mest utmanande och stressigt i ditt arbete?
15. Vad får du för stöd från dina kollegor som kanske hjälper dig hantera dessa utmaningar och den stressen?
16. Vad för stöd får du från din chef / chefer när det kommer till utmaningar och stress?

17. Kan du beskriva hur det brukar se ut under en typisk vecka, känner du ofta att ni är tillräckligt bemannade?
    a. Om inte: hur ofta skulle du säga att ni är underbemannade?
    b. En dag där ni är underbemannade, vad blir konsekvenserna för resterande personal?
18. I vilken utsträckning känner du att du har friheten att bestämma hur ditt arbete utförs och att du kan använda din kompetens till fullo?
19. När du är ledig, skulle du säga att du har lätt eller svårt att mentalt koppla bort från jobbet?
20. Om du skulle lämna yrket eller arbetsplatsen i framtiden, vad tror du skulle vara den främsta orsaken då?

Ledarskap

1. Hur skulle du beskriva din relation till din närmaste chef?
2. Hur ser kontakten mellan dig och din chef ut i vardagen?
3. Kan du berätta om hur du upplever ledarskapet när det gäller återkoppling & feedback
    a) Hur brukar återkoppling ges - formellt eller mer i vardagen?
    b) Hur skulle du beskriva den typ av feedback du får?
4. Känner du att du har möjligheten att utvecklas i ditt arbete? På vilket sätt då? Får du något stöd för det?
5. Skulle du säga att dina prestationer blir uppmärksammade av dina chefer?
6. Om något inte hade känts helt rätt, vem hade du pratat med då om detta?
    a) I vilken utsträckning känner du att det är okej att säga ifrån eller uttrycka kritik?
    b) Känner du att det är acceptabelt att be om hjälp när du behöver det?
    c) Upplever du att dina perspektiv och åsikter tas på allvar?
    d) Om någon mår dåligt, upplever du att det finns utrymme att prata om det på jobbet?
7. Har du några punkter där du tycker att ledarskapet hos er kan förbättras?
8. Finns det något vi har missat att ta upp som du vill uppmärksamma?

8.2 Informed Consent

Participants were informed about the purpose of the study and the voluntary nature of their participation before the interviews were conducted. Participation was entirely voluntary, and participants had the right to withdraw from the study at any time without providing a reason. The interviews were conducted online and recorded with the participants' consent for transcription and research purposes only. All collected data was treated confidentially and anonymized in the thesis to ensure that participants could not be identified. Audio transcriptions were deleted after transcription had been completed. Personal data, recordings,

and transcripts were handled in accordance with the General Data Protection Regulation (GDPR) and were only accessible to the researchers. Participants were informed that the collected material would solely be used for academic purposes within this bachelor thesis and would not be shared with third parties.

8.3 Use of AI

For our process of writing this thesis, we used ChatGPT and Gemini to check grammar, format the text and test ideas early in the process. The tools helped us write clearer sentences, correct grammatical mistakes and identify any overlooked errors. The main risk was that the AI might invent facts or change the meaning of our interviews. To avoid this, we did all the data analysis, coding, and literature searches ourselves. We only used AI to edit text we had already written. We realized that AI is helpful for spelling, grammar and to test ideas, but it cannot analyze qualitative data. Understanding the interviewees' actual experiences requires human judgment.