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The Lived Experiences of Nurses in France During the COVID-19 Pandemic's First Waves and their Resources for Meeting that Challenge

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ABSTRACT
The COVID-19 pandemic put France's healthcare system under extreme tension and led to significant levels of stress among healthcare professionals in general and nurses in particular. Research has shown how these elements affected nurses' physical and psychological health and manifested as insomnia, anxiety, and depressive syndromes. The present qualitative study aimed to explore the lived experiences of France's nurses as a function of their level of exposure to the virus and whether they worked in the hospital sector or practiced privately in the community during the pandemic's first wave. It also sought to describe the resources nurses used to maintain their overall health. We administered 19 qualitative interviews to 19 nurses in the autumn of 2021. The present study revealed that nurses were subjected to significant stress during the pandemic. Our data analysis enabled us to draw out three principal themes: 1) Being on the edge in stormy period; 2) Personal impact on several levels and 3) Floating together and learning. There were no significant differences between the groups that were subjected to different levels of exposure to COVID-19. All the groups were affected by the pandemic that struck a healthcare system that was already systematically fragile. Nurses were severely tested by the COVID-19 pandemic, but their consciousness of the importance of their role grew, despite questioning what meaning there was to their profession, perhaps even to their lives. The trauma still felt fresh 18 months later, during the interviews, and this cannot be ignored in future healthcare policymaking.

KEYWORDS: COVID-19, nurses, salutogenesis, stressors, health resources.

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With its rapid onset and saturation of hospital services, the COVID-19 pandemic has taken the whole world by surprise, and has had numerous major health, economic, social and political consequences. In France, the pandemic occurred in an already tense health context for many years, with hospital structures already known to be stretched to the limit due to budget restrictions and poorly equipped in terms of beds (six beds per 1,000 inhabitants) (Debout, 2020). In an attempt to contain the pandemic, France has opted to isolate its population by declaring strict lockdown periods for each wave thus entered between March and May 2020, between October and December 2020 and between April and May 2021. During these periods, hospitals operated under a "white plan," enabling the immediate mobilization of resources in terms of personnel, equipment, and organization to respond to this serious health emergency. All hospitals had to shut down their operations in order to prepare additional intensive care beds and organize COVID units. It was then a great turmoil in which all the team's energy was employed to rethink the organization (Robin, 2020). The country's healthcare system was initially energized by the pandemic and the massive influx of patients. However, the scale of the first wave, with almost 200,000 confirmed cases and 30,000 deaths by July 31, 2020 (Georger et al., 2020), quickly destabilized healthcare workers. Nurses were unable to care for patients under ideal treatment management conditions (WHO, 2023).

Despite this unparalleled situation, nurses' commitment was ceaseless, and this was recognized by civil society. The French public applauded them nightly, like heroes, throughout the first lockdown, and in recognition of their commitment during the pandemic, the World Health Organization declared 2020 the Year of the Nurse and Midwife. Despite the global appreciation of their achievements, being on the front line of France's healthcare system at this time meant constant confrontations with death, huge uncertainties, and severe work burdens (Pappa et al., 2020), all of which could have caused nurses real mental health problems.

Numerous articles and systematic reviews have described how the COVID-19 crisis affected nurses' physical and mental health (Alameddine et al., 2021; Franck et al., 2022; Huerta-González et al., 2021; Salazar de Pablo et al., 2020; Sanghera et al., 2020; Serrano-Ripoll et al., 2020; Shreffler et al., 2020). They highlighted how nurses were exposed to high levels of stress, frequently suffered from insomnia and anxiety, and these sometimes led to depressive syndromes. Studies examining nurses' occupational health during the first waves of the pandemic have mainly followed quantitative methodologies from a pathogenic perspective (Aggar et al., 2022; Armstrong et al., 2022; Galanis et al., 2021; Mo et al., 2021; Rivas et al., 2021; Vanhaecht et al., 2021). One scoping review highlighted qualitative studies of nurses' lived experiences of the COVID-19 pandemic but noted how few there were and the necessity for more international investigations comparing those experiences (Chemali et al., 2022). Today, in situations where exposure to stressors is high and almost constant, as during the pandemic, it seems legitimate to propose approaches that aim to describe the internal and external factors that support individuals' quality of life. Studies could instead use salutogenic approaches as guides to exploring the factors protective of nurses' health and helping them to transcend stressful health situations (Lindstrom, 2006). The present study's objectives were to describe nurses' lived experiences of the first wave of the COVID-19 pandemic in France, from both the qualitative and salutogenic perspectives. It included nurses working in the hospital sector and nurses working in the community, and it also sought to describe the resources they used to support their overall health.

Research Question

The aim of this study was to gain a better understanding of how French nurses working in the hospital sector and practicing privately in the community reacted during the first waves of the COVID 19 pandemic. More specifically, we sought to answer the following questions:

1. What were the nurses' experiences during this period of crisis?
2. How has this experience affected the nurses' health? and
3. What resources did the nurses use to overcome this situation?

Population and Sampling

We contacted nurses through their participation in a larger longitudinal study conducted as part of another part of the research project (Jubin et al., 2022). Of the nearly 10,000 nurses who completed the online questionnaire filled out in March 2021, 420 nurses agreed to be contacted for a follow-up interview. The population was divided into two work contexts: nurses working in the hospital sector and practicing privately in the community. In France, nurses can work either as salaried employees or as self-employed. Our population includes nurses working in both contexts. In order to collect varied experiences and information, we divided each population into three groups according to their varying degrees of exposure to the virus. The inclusion criteria for these groups were that nurses had to have had either direct exposure to the virus (in units dedicated to treating COVID-19 cases), indirect exposure to it (in units that treated some cases) or no working contact with COVID-19 patients. We selected 6, 7, and 6 nurses corresponding to these criteria, respectively. The three groups were fairly homogenous with regard to their participants' sociodemographic data, with an overall mean population age of 43.3 years old and a mean length of professional nursing experience of 19.31 years.

Data Collection

Data collection took place via semi-structured individual interviews. An interview guide helped the investigators to focus on the key themes linked to our research: (1) an exploration of nurses' lived experiences during this crisis period; (2) an understanding of the relationships between participants' lived experiences and their overall health; (3) an exploration of the resources used by participating nurses and their relationships with their overall health and occupational well-being. Two research assistants carried out our interviews using video-conferencing software, one guiding the interview with the participating nurse and the other taking notes to summarize the interview's key points. Each interview lasted approximately 45 minutes and was audio-recorded, transcribed verbatim and then sent to the participant for any potential modifications, additions and validation. Finally, to ensure the accuracy and rigor of our qualitative data and the data collection process and for monitoring purposes, researchers kept a research journal in which they noted information on the methodologies they used (development events, changes to the method, other modifications) together with theoretical (interpretations, deductions, hypotheses, theoretical knowledge) and personal notes (e.g., feelings, emotions or impressions).

Data Analysis

Each interview underwent a qualitative thematic analysis, as suggested by Braun and Clarke (Luckman, 2016). This inductive approach aims to identify and analyze the themes that emerged from interview participants' discourse. Each interview was analyzed using MaxQDA® qualitative analysis software. Data were analyzed thematically by systematically identifying units of meaning and categorizing our themes of interest (lived experiences, health and resources) into sub-themes and categories (Paillé & Mucchielli, 2008). This stage of the work was done in parallel and validated by the two researchers who collected the data so as to ensure analytical rigor throughout the process. The data were then condensed for the final presentation of our results in table form. We used the principal criteria of analytical rigor

proposed by Whittemore et al. (2001) to more explicitly ensure the scientific quality of our qualitative research: credibility, reliability, neutrality and transferability.

Results

We carried out 19 interviews between 26 October 2021 and 18 March 2022. Among the nurses who agreed to be recontacted for this interview 9 worked in hospital settings and 10 who practiced privately in the community. For both groups, we separated the degrees of exposure to COVID-19 and retained 6 nurses who had had direct contact 7 who had had indirect contact and 6 who had had no professional contact with COVID-19 patients. The three groups were fairly homogenous with regard to their participants' sociodemographic data, with an overall mean population age of 43.3 years old and a mean length of professional nursing experience of 19.31 years. The table 1 present the socio-demographic data for each participant. The socio-demographic data presented here are only minimal, in order to guarantee the anonymity of the participants.

Table 1
Socio-Demographic Data of Participants

Characteristics	Direct contact (DC)		Indirect contact (IC)		No contact (NC)	
	Hos	Com	Hos	Com	Hos	Com
Participants [n]	3	3	3	4	3	3
Sex						
Female	3	3	3	4	3	2
Male						1
Age [M]	43	38	38,6	47,2	48	45,6
Nursing seniority [SD]	17,6 (2.5)	15 (1)	15.3 (8,9)	21.7 (7,6)	25,3 (17)	16,6 (7.6)

Data analysis by coding, combining and condensing codes has enabled us to identify the different themes, sub-themes and categories presented in the tables at the beginning of each section, which help to answer the research questions. The verbatim statements presented below are annotated to show the participant's degree of professional exposure to COVID-19 (DC for direct contact, IC for indirect contact and NC for no contact) and where they worked (Hos = in a hospital; Com = practicing privately in the community). So IC.Com indicates a nurse practicing privately in the community who had indirect professional contact with the COVID-19 virus. As our analysis of nurses' verbatim statements progressed, fewer differences were observed between different exposure groups than between the hospital and private practice settings.

Analysis of the data highlighted three main themes in relation to the research questions: (1) Being on the edge in stormy period; (2) Personal impact on several levels; (3) Floating together and learning. Within each of these main themes, several sub-themes and categories are presented in the tables at the beginning of each section.

Theme 1: Nurses' Lived Experiences During This Crisis Period

This part corresponds to the first questions in the interview guide, which asked nurses to say how the pandemic had affected them, firstly professionally and then personally and whose coding has been grouped under the theme "Being on the edge in stormy period." This theme brings together the various stress factors to which the nurses were exposed and which they explained in their lived experiences of the pandemic's successive waves washing over the country. Table 2 presents the sub-themes and categories of this theme.

Table 2
Theme 1: Being on the Edge in Stormy Period

Sub-themes	Categories
A tsunami	An exceptional social context
	A disturbing personal impact
	Uncertainty and fear
Being on the frontline	Dealing with aggressiveness
	Poorly supportive management
	The specter of contamination
Going beyond one's limits	Juggling shortages
	Going beyond the normal
	Social isolation

A Tsunami

There were no remarkable differences between the exposure groups. All three groups of nurses were affected by the tsunami because it hit, as hospital nurses described it, a healthcare system that was already systemically fragile: "It was hell because we were already suffering—COVID just finished us off" (IC.Hos). Just like the general population, nurses were living in a most exceptional social context. From one day to the next, the population was ordered to stay at home. This was noticed more by nurses practicing privately in the community who observed the absence of traffic on the roads as they went to visit patients in the community. This was sometimes experienced with anxiety: "COVID shut us all in. The town was empty. It was scary" (NC.Com). The information overload thrown out by the media also contributed to reinforcing nurses' anxiety and the anxiety of the patients they were trying to reassure: "You had to calm and reassure patients who expected answers from you, without necessarily being convinced about what you were telling them—we didn't know anything at the start" (IC.Com).

The pandemic tsunami had had a disturbing personal impact on every nurse interviewed, but with different lived experiences of the situation: the weight on their shoulders, the social isolation, the fear, the uncertainties, the anger. The whole experience was burdensome, especially due to the increased workloads: "At first there was fear, uncertainty. There was one nurse for every nine patients. Very quickly there were 12 patients per nurse" (DC.Hos). These burdens have psychological consequences because they strip meaning from nurses' work: "What's hard is putting your family aside. That's the hardest thing. You do lots of things for others, and you forsake your family" (IC.Com).

Nurses felt highly exposed to these destabilizing situations that brought their values into question. This was initially because far more patients were dying than normal, as one nurse practicing in the community described: "You also lost patients who you'd been following for 5 or 10 years. Psychologically, that was tough…" (IC.Com). Death was less frequently evoked by hospital nurses who instead highlighted the difficult situations engendered by the bans on visiting patients: "The most difficult part was watching patients die alone" (IC.Hos). Their values were also struck by the decisions that had to be made, as one nurse recounted:

> *I remember getting a 75-year-old patient with COVID; he was independent, very energetic and alert. But we had received national directives not to resuscitate people beyond a certain age. I told myself we had to resuscitate somebody like him! But I knew that if he deteriorated, it was all over for him.* (DC.Hos)

All nurses have felt uncertainty and fear at one time or another. Fear was also present in nurses' lived experiences: "At the beginning, we didn't know anything about the disease's consequences. There was lots of stress when you told yourself, 'I might die today!'" (NC.Com). The absence of knowledge about the virus left nurses full of uncertainty: "Some patients get sick, others don't, there's no 'logic' in the severity of different cases" (IC.Com). It was like "a sword of Damocles named COVID" (IC.Hos) hanging above everyone's head.

This uncertainty is reinforced by information that was either excessive or inconsistent. The first months of the pandemic left the medical world in a state of uncertainty as reliable scientific data were lacking. Information proved problematic for both populations, but in different ways, whatever their level of exposure. For community nurses, the lack of coherence in the information they received was the most problematic: "It was our job to piece together all the different information they gave us" (NC.Com). However, it was sometimes the information overload that created anxiety, and the inundation of guidelines was difficult to manage: "At the beginning, I was assailed by lots of emails with rules and norms" (DC.Com). For hospital nurses, it was the continuously changing information and the rapidly changing treatment recommendations that were worst: "The guidelines changed rapidly: masks for everybody one day and the next day it was only for some" (IC.Hos).

Being on the Frontline

The pandemic forced nurses out of their normal working frameworks and thrust them into the frontline. Whatever their level of exposure to COVID-19, hospital nurses and private practice nurses found themselves on the frontline, dealing with patients. Indeed, private practice nurses really felt that they were being sent to a battlefront alone: "It was war, and we were the little soldiers. We were off to the front, and there, either you got hit or you didn't!" (NC.Com). For hospital nurses, that frontline role meant being alone with patients, accompanying them through difficult moments without their families and then having to deal with those families: "Managing visits was difficult. Some people died alone" (IC.Hos).

Whether in the hospital or at home, the nurses had to deal with aggressiveness. In their nurse, the population had found someone to whom they could pour out all their anxieties. During home visits, mistrust sets in, as this nurse points out: "The patients were very anxious, with some of them being rather aggressive, saying "you're going to infect me"" (DC.Com). Even if the general population expressed their support and sympathy for nurses, many of them described how they had been subjected to aggressivity from some people: "There was the aggressivity of people who felt misunderstood, and then we got insulted by their families" (IC.Hos).

Whatever their level of exposure to the virus, nurses did not feel they had the backing of their management. Whether working in hospitals or in the community, they all decried a lack of support. Hospital nurses denounced their leadership:

> *I wasn't support by the hospital management, and I didn't get the impression we were being supported by the care unit management, but rather that they were spying on us and monitoring the equipment we were using, how many masks were being used ...* (DC.Hos)

Another nurse went further: "The hierarchy did nothing to help, even if they said they understood. We weren't allowed to complain" (IC.Hos). Nurses practicing privately in the community felt abandoned by their professional bodies, as one nurse recounted: "The unions [laughs] were six months behind" (NC.Com). Nurses also felt that "there was no recognition for some of the things we did. It was a lack of respect" (IC.Com). Indeed, according to this nurse:

> *Sometimes you get the impression that the ministerial and governmental authorities are a little bit cut off from the reality in the field, because there's often a mismatch between the reality in people's homes and the protocols and guidelines put in place.* (NC.Com)

As the virus spread, most nurses became scared that they might transmit it themselves: "I felt stressed by the risk that I'd spread the virus from one patient to another" (IC.Com). For the first time and in clear view, nurses' professional universes crashed into their private lives with the risks of contamination, as one nurse explained:

> *At the moment there was no fear to go to work, but on the ward, I realized that I hadn't anticipated exposing my family to such risks (...). Thankfully, there was nobody at risk in my entourage, but that fear built up inside me.* (DC.Hos)

Going Beyond One's Limits

The nurses had to juggle all kinds of shortages of both equipment and personnel. There are differences here between hospital exposure groups, since nurses with no or indirect contact describe a flagrant lack of resources: "At first, there wasn't much equipment, which was mainly deployed in the ICU" (IC.Hos). Staff are redeployed to intensive care and emergency departments. Nurses not only had to change the way they worked but some hospital nurses also had to work on wards with different specialties to help absorb the influx of COVID-19 patients. Some specialties were stripped of staff who were sent to support COVID wards: "It had a huge impact on my internal medicine ward because during COVID, half the team had gone to COVID wards, and they gave us interim staff. It was tough" (DC.Hos). Some specialties closed down and their nurses were redeployed elsewhere:

> *I found myself in the dialysis unit. This was the start of my disillusionment because, despite my experience, there were such unrealistically high technical demands that it was very tough. I held on, but I cried a lot when I got home in the evening.* (DC.Hos)

For nurses practicing privately in the community, these changes in practice meant that they had to care for new types of patients: "There was more technical care to be done" (IC.Com). Shortage forces nurses to go above and beyond the normal. Nurses had to go beyond the usual limits they put on their professional commitment and engagement, but with the risk of endangering their health: "It meant going beyond one's limits; it was a kind of suicidal unselfishness" (IC.Hos). "The job meant working yourself to death or changing job" (IC.Hos). Some nurses got angry:

> *I felt angry about the administrative and political slowness, although I was conscious that it was easier to be in my shoes and to criticize than to be in theirs and make decisions in the face of the unknown, it was a context with continuously changing rules.* (IC.Com)

Their points of reference change and transferring nurses to wards with other specialties took them outside their comfort zone. Even the years of professional experience they had built up failed to support them when it came to dealing with a virus, they knew nothing about:

> *My experience isn't relevant with COVID patients (…) In principle, I can 'sense' when a patient is about to decompensate, but here, I could come back into their room just afterwards and see they were in respiratory depression that I just hadn't seen coming. It was frightening.* (DC.Hos)

Social isolation also weighed heavily on nurses: "I feel more withdrawn than before, more isolated from society—it weighs on me" (DC.Hos). This isolation was all the more disturbing and difficult to bear because it was also partly due to the stigmatization that nurses experienced: "I really was in isolation because my working on a COVID ward scared my whole entourage" (DC.Hos).

Theme 2: Overall Health

This part corresponds to the second set of questions in the interview guide, which asked nurses to describe the impact the pandemic had had on their physical and psychological health and whose coding has been grouped under the theme "Personal impact on several levels." There were no differences between the groups according to their levels of exposure. Table 3 presents the sub-themes and categories of this theme.

Table 3
Theme 2: Personal Impact on Several Levels

Sub-themes	Categories
I'm doing fine	I'm used to
	No impact
Physical impact	Physiological mechanisms of long-term stress
	Physical tiredness
	COVID 19 sequelae
Psychological impact	Greater fragility
	Burnout
	Worries

I'm Doing Fine

A few nurses mentioned that COVID 19 had had no effect on their health at all, as one nurse said, "I didn't have too bad a time either physically or psychologically" (IC.Com). Nurses in the community were the most likely to say that COVID had no impact on their health. They absorbed the overload like this nurse: "I've always had a frenetic rhythm" (IC.Com).

Physical Impact

The physical symptoms reported by nurses as linked to their prolonged stress included pain (especially muscle and joint pain), sleep disorders, eating disorders leading to weight loss or weight gain ("I lost 10 kg", IC.Hos) or dermatological problems: "My eczema came back" (NC.Com). Nurses still describe a loss of energy and significant physical fatigue: "No particular problems related to COVID, but tired of these two years" (DC.Com). Some nurses who have had COVID have suffered after-effects: "I have pneumological sequelae of COVID" (DC.Hosp).

Psychological Impact

Nurses describe greater fragility with exacerbated sensitivity: “Psychologically, I’ve felt more like a short fuse. I can explode more easily, which didn’t happen before” (NC.Hos). Hospital nurses describe the most psychic suffering, with the words “crying,” “anguish,” and “feeling affected all the time” recurring frequently.

Stress also had an impact on psychological health, with nurses mentioning mental fatigue most frequently: “Great psychological fatigue: it lasted so long, and there was the fear of not doing my job properly any more” (DC.Hos). Depression and anxiety were also reported: “Depression crept up on you little by little through your morbid thoughts. They were talking about lots of deaths” (NC.Com). These effects sometimes led to sick leave and even burnouts: “I was on sick leave that was put down to burnout” (IC.Hos). Even in their interviews for this study, some nurses were in tears as they spoke about their lived experiences. The trauma was still fresh: “I still feel affected by it” (DC.Hos). Nurses describe latent worry and spoke of “massive anxiety” (DC.Com), this anxiety persists in the background: “I feel much more anxious than before” (DC.Hos).

Nurses expressed their worries about the healthcare system’s capacity to cope with a new pandemic: “I’m worried about what happens next, because if we were faced with a more aggressive virus, say cholera, which created even more damage, we’re not ready!” (NC.Com).

Theme 3: Resources Used

This last part corresponds to questions about how nurses preserve their health and whose coding has been grouped under the theme “Floating together and learning”. This theme brought together sub-themes and categories about the resources nurses used to maintain their health status. There were no differences according to different levels of exposure and very little difference between hospital and community nurses.

Table 4
Theme 3: Floating Together and Learning

Sub-themes	Categories
Keeping one’s head above water	Taking care of oneself
	Putting things into perspective.
	Changing roles or profession
Social support	Support from one’s team.
	Support from family and friends
Learning from lessons	A new awareness of one’s role as a nurse.
	A reappraisal of one’s professional and personal lives

Keeping One’s Head Above Water

Nurses used a number of strategies to keep their heads above water and to take care of themselves. Some did specific activities (gardening, reading, meditation, sport), some received professional health support (hypnosis, alternative therapies, psychotherapy), and some simply protected themselves by avoiding stressors: “I stopped watching the television news as of April 2020” (IC.Com). Another nurse changed her habits: “My alcohol consumption went up after my shifts during my frequent video get-togethers with my friends—not much, but more than usual” (NC.Com).

What really helped the nurses in both groups, regardless of their degree of exposure to the virus, was their ability to put things into perspective. At the beginning, when nurses realized that all their colleagues were facing the same problems, it put things into perspective despite the clearly difficult situation: “But the fact that we realized it was the same all over France helped us not to set off a revolution within our institution” (DC.Hos). Experience helped nurses put things into perspective, as this nurse explained:

> *I’ve realized that, with age and maturity, I’ve learnt to manage my natural anxiety by taking things step by step: first I observe things, then I take a step back, I put things into perspective, and finally I bounce back.* (IC.Com)

Finally, several nurses mentioned the possibility of leaving, especially those working in hospitals. Numerous nurses described how they wanted to change their specialty or even leave the nursing profession entirely. If that idea had been present before the pandemic, then the burdens of COVID-19 had reaffirmed them. Hospital nurses especially evoked leaving, perhaps to practice privately in the community. Nurses had observed their colleagues around them leaving:

> *On my ward, very experienced nurses—with more than 20 years in the specialty—are leaving—or talking about doing so— either to practice privately [in the community] or to do something else entirely (open a patisserie or a gite!).* (DC.Hos)

One nurse said that the only thing that was stopping her from cracking was the thought that the crisis was nearly over: “Things are going better since I asked for a year of leave without pay” (NC.Hos). Nurses practicing privately, on the other hand, were exploring new professional options: “I want to become a nursing trainer: I’ve got a few options on the table” (DC.Com).

Social Support

All nurses said they had benefited from the mutual support provided within their team and by their private entourage. Support from within one’s own care team was an important resource, persistently highlighted by hospital nurses. The team was first and foremost moral support, “We passed each other the paper tissues” (IC.Hos), and then a professional one, “Very quickly, a sort of osmosis occurred within the team, with a common motivation to serve the public hospital system” (IC.Hos).

Some care teams compensated for the heavy workload by trying to create a fresh dynamic where humor took on an important role, as on this ward: “We tried to laugh a lot. We organized games amongst ourselves on the ward. Koh-Lanta, for example, so that you could win the show’s *Immunity Necklace*, et cetera” (DC.Hos).

It was similar for nurses working in the community—although they were still working one-on-one with their patients, they described closer synergies with their peers during the pandemic: “We organized a WhatsApp group with all the community nurses in the region so that we could be in constant contact” (NC.Com). “Communication between colleagues was reinforced” (NC.Com).

Overall, whether working in hospitals or in the community, and whatever their level of exposure to COVID-19, nurses unwound their tension or recharged their batteries in their private spheres: “My family and my partner were there for me; I was able to get things off my chest emotionally” (NC.Com). Also: “I was very well supported by my family; we got together as a family in the evening” (DC.Hos). Nevertheless, for some, the disequilibrium between

work-life and home-life made a tense situation even worse. Crowded homes and the pressures of children having to follow school classes there were also the sources of tension: “The tension in their relationship, being on top of each other—neither she nor her husband were going through a good patch” (NC.Com).

Learning from Lessons

This sub-theme mainly assembled the elements that concluded the interview guide and helped the investigators categorize the lessons learnt from the pandemic period: a new awareness about nurses’ roles in the healthcare system, a reappraisal of nurses’ professional and personal lives. Putting the pandemic situation into perspective and learning from it helped the nurses in their day-to-day work.

The pandemic helped nurses to develop a new awareness of their roles within the healthcare system. Community nurses greatly questioned their profession’s social role, with the result that the pandemic either reinforced their opinions about this, “The situation gave my job even more meaning” (NC.Com), or utterly disillusioned them, “We’ve had it with the lack of consideration shown to healthcare professionals! I’ve matured. We shouldn’t be treated like dogs” (NC.Com). The health crisis confirmed a pre-existing malaise in the profession: “I don’t think there’s any possibility of me continuing to do my job in the future. I love my job, but conditions have deteriorated so much in terms of resources and ways of doing things” (DC.Com)

However, the pandemic had created an opportunity to make the nursing profession more visible: “It’s an opportunity to express yourself, to show how valuable you are—especially to patients” (IC.Com) and, “It enabled us to highlight the difficulties in the care sector” (IC.Hos). They were conscious of their important role in society: “The population really needs us” (IC.Hos). However, these feelings frayed over time. “This job is more than just a way to make a living” (IC.Com).

At one time or another during the pandemic, all the nurses asked questions about their jobs’ meaning—even about what life meant to them. The health crisis revealed just how important the resources for maintaining their health truly were, and they felt sure to keep this in mind in the future: “We’ve got to stop sacrificing ourselves! We’re just starting to discover that all you have to do is say ‘No!’” (IC.Hos). “This shows that we’ve got our behavior all wrong. You have to protect yourself and not self-destruct anymore” (IC.Hos). One nurse revealed: “We’ve moved on from, ‘She’s always on a break’ to ‘She’s trying to avoid a burnout!’” (IC.Hos).

The pandemic allowed nurses to ask themselves what was important: “Being a nurse and being around serious illnesses every day, you tell yourself that you should make the most of life, but since COVID, I’ve told myself this a bit more” (IC.Com). The crisis enabled a readjustment: “Personally, it enabled me to get back to what’s important. I pulled my nose out of my telephone screen. I feel more grounded in reality” (NC.Com). It was a period in which nurses reappraised their practice, as one community nurse noted: “I don’t worry myself any more about disagreeable people! It really used to get to me, but now, I either ignore them or I have a go back at them” (NC.Com).

Discussion

To explore the lived experiences of French nurses during the first waves of the COVID-19 pandemic and to describe the resources they used to maintain their general health, we conducted 19 interviews. This discussion is structured around three axes that address the research questions: the perceived stress, its impact on health and the resources used to deal with it.

In France, as in many other countries, the COVID-19 pandemic exacerbated the crisis in the hospital system, which was already under considerable pressure (Comité Consultatif National Éthique [CCNE], 2022).For a great many nurses, the COVID-19 pandemic revealed a crisis in nursing values, one trapped between a philosophy of care imbued with humanist values—the type of care they wanted to practice—and the healthcare system's management by medical act or intervention. This type of management, notably the T2A financing system used in France, only pays for technical medical or nursing acts, such that all the relational aspects of care—the basis of nursing care—become invisible to the system, reinforcing the nursing profession's position as one secondary to or 'merely' supporting physicians (CCNE, 2022). It was against this background that the pandemic occurred, and it was experienced as a tsunami by caregivers who found themselves caught up in the first waves. This notion of "viral tsunami" (Grimont-Rolland, 2022) hugely impacted the organizational, professional, personal, economic and social dimensions of the country's healthcare system. Indeed, the tsunami lasted for several years, despite the fact that vaccination, among other things, progressively managed to control the virus' propagation. The implementation of a series of lockdowns, maintaining the organization of care throughout a crisis threatening the very healthcare system itself, and the critical health statuses in which COVID-19 patients found themselves, were all significant stressors on nurses.

Most of the studies looking at the pandemic's impacts on nurses were primarily interested in those who had been in direct contact with COVID-19 patients (Aggar et al., 2022; Alizadeh et al., 2020; Ding et al., 2022; Fernández-Castillo et al., 2021; Guttormson et al., 2022; Hoernke et al., 2021; Huerta-González et al., 2021; Moradi et al., 2021; Van Steenkiste et al., 2022). The originality of our study lies in the fact that, whatever their degree of exposure to the virus, the COVID-19 pandemic severely tested the psychological and physical health of all nurses and left its mark on many of them. All nursing personnel were subjected to very significant stress during the pandemic. What's more, having nurses working in two different contexts, i.e. hospital and community, enabled us to identify points of particularity.

Hospital nurses in direct contact described the stress factors associated with the massive inflow of patients. Faced with the massive influx of critically ill patients, all institutions have reinforced their dedicated departments. The nurses in these departments had to supervise the new staff, who were not always accustomed to intensive care, while at the same time managing the most complex cases. Nurses were exposed to very difficult situations, including greatly increased mortality. Although they may be used to deaths, nurses were not ready for the sheer numbers and were traumatized by the relative youth of some victims, the fact that patients died alone without their families present, the uncertainties of the treatments provided and the sudden decompensations that some patients underwent. Ding et al. (2022) underlined that frontline nurses who were in direct contact with patients with COVID-19 experienced feelings of helplessness and guilt when certain patients' health statuses deteriorated. As a result, frontline nurses are faced with additional distress (Kelley et al., 2022). It seems "normal" to think that a nurse is used to seeing things that would be difficult for people outside the healthcare field. However, in these extreme situations, the burden was very great and was underestimated, leading nurses to feel that they had not been heard by management. Nurses working in the community had to deal with aggressive patients and patients who refused care. They also had to cope with the lack of information and integrate new tasks such as patient education on protective measures and signs to watch out for into COVID 19. Added to this, for both groups, was the fear of spreading the virus to patients or within the family circle. It is interesting to note that there were no major differences in the degree of exposure to the virus in the experiences of nurses working in the community. This can probably be explained by the fact that they had the choice of whether or not to become involved in the care of COVID 19 patients. This freedom enabled them to work according to their values, that is, not to expose their usual patients to the risk of contamination.

Nurses working in the hospital sector who had no contact with infected patients, or only indirectly, were also exposed to high levels of stress because they felt less prepared to cope, with less favorable working conditions and less appropriate equipment. For these nurses, the stress factors are different, and it is above all the uncertainty linked to working conditions that is highlighted. In these departments, life goes on, but staff are redeployed to reinforce intensive care units, and working hours have to be increased while ensuring the same quality of care with fewer staff. Furthermore, redeployment is a source of stress, as it generates the fear of being sent to a department where the redeployed nurse's knowledge is not sufficient to work with a sense of security. This is described in the literature (Li et al., 2022) as extremely anxiety-provoking. In addition, the emphasis was placed on emergency and intensive care units (ICUs), for which numerous benefits were offered (massage, packed lunch, chocolate, etc.). Thus, frontline nurses benefitted from the broad solidarity of their peers, colleagues and physicians, and suffered less severely from the lack of personal protective equipment because intensive care units were prioritized for them (Ding et al., 2022).

Constant exposure to chronic stress seems to have been maintained throughout the first waves, with consequences for the health of all nurses. In our study, only two community nurses reported no impact on their health. All the others expressed physical and/or psychological impacts. Nurses in direct contact describe the additional burden of having to control everything and guarantee the smooth running of the unit. Nurses in direct contact with the dedicated COVID-19 units seemed to be the most "traumatized," as they were the most unable to put their experience into words. Several authors have focused on front-line caregivers (Alizadeh et al., 2020; Fernández-Castillo et al., 2021; Hoernke et al., 2021; Moradi et al., 2021) and have underlined the pandemic's negative impacts on physical health, citing the appearance of symptoms such as chronic fatigue and sleep disorders, and on mental health, with greater incidences of post-traumatic stress, depression, anxiety and distress, and a significant increase in suicide attempts. In their mixed-methods study using a cross-sectional online survey, Crowe et al. (2022) show that the vast majority of intensive care nurses reported symptoms of post-traumatic stress (74%), depression (70%), anxiety (57%) and stress (61%). Hospital or community nurses in direct contact described physical fatigue verging on exhaustion. Several elements have been linked to these phenomena, including exposure to continued significant levels of stress, the lack of equipment, increasing workloads, worries associated with the care given itself and with patients, and the high degree of patient mortality and ethical dilemmas (Chemali et al., 2022). A study by Rossi et al. (2021) revealed that being a frontline healthcare professional increased the risks of developing the symptoms of mental health disorders like depression and anxiety.

Hospital and community nurses without contact or with indirect contact, also describe fatigue, anxiety and there is little difference between the two groups. The results of the study indicate that to keep their heads above water, nurses in both groups mobilized slightly different resources. They all tried to take care of themselves, whether through various leisure activities or by consulting professionals. Nurses had to learn to recognize their limits in order to protect themselves. However, on this last point, the expression of this resource took different forms for community nurses, who were able to choose how they worked, whereas hospital nurses had no choice but to go on sick leave. Five out of nine nurses said they had to stop work due to burnout at some point during the pandemic. This led the nurses to get to know themselves better as professionals in times of crisis: revealing skills and self-confidence for some, developing professional assertiveness for others. For all the nurses, the crisis acted like a magnifying mirror, highlighting all the problems associated with their work. There are those who are assertive and feel at home, and those who feel the need to change, because the work no longer corresponds to their values. There are no differences here between the exposure groups, although it's true that direct-contact nurses are more inclined to find real meaning in their work because they feel they've accomplished something great. However, they are just as disillusioned

as the others about the future and what management has learned from the crisis: we're going to the wall.

The private sphere is one of the resources most cited by all participants. Nurses are thinking about “how far to sacrifice those around them” and, more broadly, their private lives. How far will they accept the imbalance? The challenge for the future is to answer this question. The hospital nurses also found overwhelming support within their teams. The team is recognized as an important resource for nurses (Jun & Rosemberg, 2022). However, even if the team has proved to be a solid anchor, this resource is depleted over time. For community nurses, who tend to work alone, this was a lack, and they felt the need to be supported by their peers. They have therefore created communities through a number of initiatives (e.g., WhatsApp groups). Social support and recognition of the value of their work also played a role in supporting nurses. However, when we meet the nurses in autumn 2021, they are already skeptical about this support. Nurses’ during the first lockdown saw them celebrated as heroes by the French population. Thanks to the support of the media, normal citizens either discovered or recognized nurses’ added value, but the fact remains that their lived experiences, at the very heart of the pandemic, received little media attention and were often sidelined because they were seen as secondary. As a consequence,

> *although the media’s recognition of nurses as health experts is beneficial, what nurses need most in order to influence public debates and health policy is the freedom to express themselves, the capacity to amplify their strong collective voice and the power of the media and technology, including social media.* (Gagnon & Perron, 2020, p. 113)

However, this was not the case. Public debates on the pandemic did not consider the position that France’s nurses found themselves in, and, unfortunately, their voice remains inaudible today despite their representative bodies. Regardless of their level of exposure to COVID 19, all nurses who participated in the present study described how they were confronted by numerous stressors linked to their wards’ reorganization, staff secondments elsewhere, isolation, uncertainties about what truly awaited their patients and the perceived lack of support from their management. All these stressors were recurrent themes in the literature on the pandemic (Chemali et al., 2022). The trauma remains present and cannot be ignored. Nurses’ perceptions that they had been thrown like cannon fodder into the battle against COVID-19 are important to highlight because they are hardly covered in the literature, which concentrated on aspects linked to their psychosocial health. These ideas were able to be expressed, however, in some daily newspapers, such as *Ouest France*, which highlighted nurses’ extreme working conditions and their feelings of being left alone to struggle in an uncertain and stressful universe (Travadon, 2020). Military analogies became commonplace, such as soldiers sent to battle on the frontline, where death was always a possibility because the enemy’s advance had to be held back. The notion of being a “good little soldier” was almost a stereotype of how nurses were perceived pre-pandemic—as honest, hard-working, devoted to their jobs, endowed with strong ethical integrity but mediocre career prospects, poor working conditions, and restricted or marginalized to the roles of subordinates (to physicians) (Girvin et al., 2016). Has the COVID-19 health crisis changed these perspectives at all? France’s healthcare policies do not seem to be heading towards any changes.

In this unpromising environment for nurses, it is not surprising that the International Council of Nurses (2021) put out a press release, on 13 January 2021, suggesting that the COVID-19 health crisis would trigger a wave of resignations and early retirements if national healthcare authorities did not immediately take appropriate measures. The Council mentioned that there was already a worldwide shortfall of six million nurses and that the huge numbers of retirements expected over the next ten years could severely strain healthcare systems’ capacities

to care for their citizens' health. Many different countries' healthcare systems are suffering from growing shortages of healthcare professionals, including the nurses who have felt obliged to leave the profession. Despite different international bodies having raised the alarm about this situation and the fact that France's healthcare system is in a constant state of readjustment to it—via, among other measures, a chronic schedule of bed closures—politicians still seem very reluctant to take the necessary measures. Recognition of the added value nurses bring to healthcare systems should amount to far more than citizens' applause on their balconies before the evening news—after two months, nurses fell back into obscurity. A realistic political approach is required to return nurses to the position they deserve and integrate the profession into all healthcare decision-making.

Force and Limit

The strengths lie in the representation of all degrees of exposure to COVID 19, and in the distinction between the two working contexts of French nurses, that is, hospital and community. Due to geographical distance, we had to conduct the interviews by videoconference, which may have hampered the richness of the exchanges. However, we had the participants validate each interview by transcribing it for them. They were then given the opportunity to correct or add to the content. Another limitation is that the interviews were conducted from a retrospective perspective, covering several waves of the pandemic, so there may be some hindsight and interpretation of events that are no longer current and may therefore be forgotten or partially reconstructed.

Conclusion

The present study explored the lived experiences of nurses during the COVID-19 pandemic through 19 interviews. It revealed that all of France's nurses were affected by this healthcare crisis, whether or not they had practiced in intensive care units dedicated to COVID-19 patients. Indeed, the spotlight had singled out these staff, leaving those working in other specialties in the shade despite the pandemic's effects on them. Most of the hospital nurses interviewed had experienced the health crisis as if it were a tsunami, but with different levels of effects depending on their exposure to the disease. They had sometimes been forced to work in contradiction to their personal nursing values and had coped with situations by going beyond their own limits despite a lack of resources. Community nurses felt isolated on the front line.

The pandemic tested nurses severely, whatever their work setting or level of exposure to the disease, so much so that we should now be caring for the healthcare professionals who were caring for all the patients during the pandemic. The crisis accentuated existing stressors, leading nurses to mobilize more resources. They realized that they were giving more than they were receiving, creating an imbalance. And yet, when it comes to weighing up their options, many of them want to leave the profession. The challenge is to retain nurses in their jobs by thinking about how to support them with specific resources.

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References

Aggar, C., Samios, C., Penman, O., Whiteing, N., Massey, D., Rafferty, R., Bowen, K., & Stephens, A. (2022). The impact of COVID-19 pandemic-related stress experienced by Australian nurses. *International Journal of Mental Health Nursing*, *31*(1), 91-103. https://doi.org/10.1111/inm.12938

Alameddine, M., Clinton, M., Bou-Karroum, K., Richa, N., & Doumit, M. A. A. (2021). Factors Associated With the Resilience of Nurses During the COVID-19 Pandemic. *Worldviews on Evidence-Based Nursing*, *18*(6), 320-331. https://doi.org/10.1111/wvn.12544

Alizadeh, A., Khankeh, H. R., Barati, M., Ahmadi, Y., Hadian, A., & Azizi, M. (2020). Psychological distress among Iranian health-care providers exposed to coronavirus disease 2019 (COVID-19) : A qualitative study. *BMC Psychiatry*, *20*, 494. https://doi.org/10.1186/s12888-020-02889-2

Armstrong, S. J., Porter, J. E., Larkins, J.-A., & Mesagno, C. (2022). Burnout, stress and resilience of an Australian regional hospital during COVID-19 : A longitudinal study. *BMC Health Services Research*, *22*(1), 1115. https://doi.org/10.1186/s12913-022-08409-0

CCNE. (2022, octobre 20). *AVIS 140 Repenser le système de soins sur un fondement éthique [OPINION 140 Rethinking the healthcare system on an ethical basis]* [Comité consultatif national d'éthique pour les sciences de la vie et de la santé]. https://www.ccne-ethique.fr/sites/default/files/2022-11/Avis140_Final_0.pdf

Chemali, S., Mari-Sáez, A., El Bcheraoui, C., & Weishaar, H. (2022). Health care workers' experiences during the COVID-19 pandemic : A scoping review. *Human Resources for Health*, *20*(1), 27. https://doi.org/10.1186/s12960-022-00724-1

Crowe, S., Howard, A. F., & Vanderspank, B. (2022). The mental health impact of the COVID-19 pandemic on Canadian critical care nurses. *Intensive and Critical Care Nursing*, *71*, 103241. https://doi.org/10.1016/j.iccn.2022.103241

Debout, C. (2020). Pandémie de Covid-19 et pénurie infirmière en France : Un phénomène prévisible. [Covid-19 pandemic and nursing shortage in France: a predictable phenomenon]. *Revue Francophone Internationale de Recherche Infirmière*, *6*(3), 100200. https://doi.org/10.1016/j.refiri.2020.100200

Ding, S., Deng, S., Zhang, Y., Wang, Q., Liu, Z., Huang, J., & Yang, X. (2022). Experiences and needs of front-line nurses during the COVID-19 pandemic : A systematic review and qualitative meta-synthesis. *Frontiers in Public Health*, *10*, 805631. https://doi.org/10.3389/fpubh.2022.805631

Fernández-Castillo, R.-J., González-Caro, M.-D., Fernández-García, E., Porcel-Gálvez, A.-M., & Garnacho-Montero, J. (2021). Intensive care nurses' experiences during the COVID-19 pandemic : A qualitative study. *Nursing in Critical Care*, *26*(5), 397-406. https://doi.org/10.1111/nicc.12589

Franck, E., Goossens, E., Haegdorens, F., Geuens, N., Portzky, M., Tytens, T., Dilles, T., Beeckman, K., Timmermans, O., Slootmans, S., Van Rompaey, B., & Van Bogaert, P. (2022). Role of resilience in healthcare workers' distress and somatization during the COVID-19 pandemic : A cross-sectional study across Flanders, Belgium. *Nursing Open*, *9*(2), 1181-1189. https://doi.org/10.1002/nop2.1159

Gagnon, M., & Perron, A. (2020). Nursing Voices during COVID-19 : An Analysis of Canadian Media Coverage. *Aporia*, *12*, 109-113. https://doi.org/10.18192/aporia.v12i1.4842

Galanis, P., Vraka, I., Fragkou, D., Bilali, A., & Kaitelidou, D. (2021). Nurses' burnout and associated risk factors during the COVID-19 pandemic : A systematic review and meta-analysis. *Journal of Advanced Nursing*, *77*(8), 3286-3302. https://doi.org/10.1111/jan.14839

Georger, F., Santos, E. D., Gazagne, L., Berdagué, P., Saib, A., Nahon, S., Piquet, J., & Amara, W. (2020). COV IMPACT : analyse des différents facteurs de stress du personnel hospitalier dans 2 centres hospitaliers en France lors de la pandémie COVID-19 [COV IMPACT: analysis of stress factors among hospital staff in 2 French hospitals during the COVID-19 pandemic]. *Annales de Cardiologie et d'Angéiologie*, *69*(5), 227-232. https://doi.org/10.1016/j.ancard.2020.09.005

Girvin, J., Jackson, D., & Hutchinson, M. (2016). Contemporary public perceptions of nursing : A systematic review and narrative synthesis of the international research evidence. *Journal of Nursing Management*, *24*(8), 994-1006. https://doi.org/10.1111/jonm.12413

Grimont-Rolland, E. (2022). COVID-19 : Expériences, aspects organisationnels et éthiques dans un établissement de soins pour personnes polyhandicapées et multihandicapées [Covid-19 : Organizational measures and ethical questions in rehabilitation center for persons with severe handicap and disability]. *Ethique & sante*, *19*(4), 210-216. https://doi.org/10.1016/j.etiqe.2022.08.004

Guttormson, J. L., Calkins, K., McAndrew, N., Fitzgerald, J., Losurdo, H., & Loonsfoot, D. (2022). Critical care nurse burnout, moral distress, and mental health during the COVID-19 pandemic : A United States Survey. *Heart & Lung*, *55*, 127-133.

Hoernke, K., Djellouli, N., Andrews, L., Lewis-Jackson, S., Manby, L., Martin, S., Vanderslott, S., & Vindrola-Padros, C. (2021). Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal. *BMJ Open*, *11*(1), e046199. https://doi.org/10.1136/bmjopen-2020-046199

Huerta-González, S., Selva-Medrano, D., López-Espuela, F., Caro-Alonso, P. Á., Novo, A., & Rodríguez-Martín, B. (2021). The Psychological Impact of COVID-19 on Front Line Nurses : A Synthesis of Qualitative Evidence. *International Journal of Environmental Research and Public Health*, *18*(24), 12975. https://doi.org/10.3390/ijerph182412975

Jubin, J., Delmas, P., Gilles, I., Oulevey Bachmann, A., & Ortoleva Bucher, C. (2022). Protective Factors and Coping Styles Associated with Quality of Life during the COVID-19 Pandemic : A Comparison of Hospital or Care Institution and Private Practice Nurses. *International Journal of Environmental Research and Public Health*, *19*(12), 7112. https://doi.org/10.3390/ijerph19127112

Jun, J., & Rosemberg, M.-A. S. (2022). I am a nurse, not a martyr : Qualitative investigation of nurses' experiences during onset of the coronavirus pandemic. *Policy, Politics, & Nursing Practice*, *23*(1), 48-55.

Kelley, M. M., Zadvinskis, I. M., Miller, P. S., Monturo, C., Norful, A. A., O'Mathúna, D., Roberts, H., Smith, J., Tucker, S., Zellefrow, C., & others. (2022). United States nurses' experiences during the COVID-19 pandemic : A grounded theory. *Journal of clinical nursing*, *31*(15-16), 2167-2180.

Li, T.-M., Pien, L.-C., Kao, C.-C., Kubo, T., & Cheng, W.-J. (2022). Effects of work conditions and organisational strategies on nurses' mental health during the COVID-19 pandemic. *Journal of Nursing Management*, *30*(1), 71-78.

Lindstrom, B. (2006). Contextualizing salutogenesis and Antonovsky in public health development. *Health Promotion International*, *21*(3), 238-244. https://doi.org/10.1093/heapro/dal016

Luckman, S. (2016). Virginia Braun and Victoria Clarke, Successful qualitative research : A practical guide for beginners. *Feminism & Psychology*, *26*(3), 387-391. https://doi.org/10.1177/0959353515614115

Mo, Y., Tao, P., Liu, G., Chen, L., Li, G., Lu, S., Zhang, G., Liang, R., & Huang, H. (2021). Post-Traumatic Growth of Nurses Who Faced the COVID-19 Epidemic and Its Correlation With Professional Self-Identity and Social Support. *Frontiers in Psychiatry*, *12*, 562938. https://doi.org/10.3389/fpsyt.2021.562938

Moradi, Y., Baghaei, R., Hosseingholipour, K., & Mollazadeh, F. (2021). Challenges experienced by ICU nurses throughout the provision of care for COVID-19 patients : A qualitative study. *Journal of Nursing Management*, *29*(5), 1159-1168. https://doi.org/10.1111/jonm.13254

Paillé, P., & Mucchielli, A. (2008). L'analyse qualitative en sciences humaines et sociales,. *Sciences Humaines & Sociales», Paris, Armand Colin*.

Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic : A systematic review and meta-analysis. *Brain Behav Immun*, *88*, 901-907. https://doi.org/10.1016/j.bbi.2020.05.026

Rivas, N., López, M., Castro, M.-J., Luis-Vian, S., Fernández-Castro, M., Cao, M.-J., García, S., Velasco-Gonzalez, V., & Jiménez, J.-M. (2021). Analysis of Burnout Syndrome and Resilience in Nurses throughout the COVID-19 Pandemic : A Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, *18*(19). https://doi.org/10.3390/ijerph181910470

Robin, F. (2020). Quelques réflexions sur la souffrance des soignants français dans la crise sanitaire du Covid-19 [Some reflections on the suffering of French caregivers in the Covid-19 health crisis]. *PSN*, *18*(3), 107-113. Cairn.info.

Rossi, R., Socci, V., Jannini, T. B., Pacitti, F., Siracusano, A., Rossi, A., & Di Lorenzo, G. (2021). Mental Health Outcomes Among Italian Health Care Workers During the COVID-19 Pandemic. *JAMA Network Open*, *4*(11), e2136143. https://doi.org/10.1001/jamanetworkopen.2021.36143

Salazar de Pablo, G., Vaquerizo-Serrano, J., Catalan, A., Arango, C., Moreno, C., Ferre, F., Shin, J. I., Sullivan, S., Brondino, N., Solmi, M., & Fusar-Poli, P. (2020). Impact of coronavirus syndromes on physical and mental health of health care workers : Systematic review and meta-analysis. *Journal of Affective Disorders*, *275*, 48-57. https://doi.org/10.1016/j.jad.2020.06.022

Sanghera, J., Pattani, N., Hashmi, Y., Varley, K. F., Cheruvu, M. S., Bradley, A., & Burke, J. R. (2020). The impact of SARS-CoV-2 on the mental health of healthcare workers in a hospital setting-A Systematic Review. *Journal of Occupational Health*, *62*(1), e12175. https://doi.org/10.1002/1348-9585.12175

Serrano-Ripoll, M. J., Meneses-Echavez, J. F., Ricci-Cabello, I., Fraile-Navarro, D., Fiol-deRoque, M. A., Pastor-Moreno, G., Castro, A., Ruiz-Pérez, I., Zamanillo Campos, R., & Gonçalves-Bradley, D. C. (2020). Impact of viral epidemic outbreaks on mental health of healthcare workers : A rapid systematic review and meta-analysis. *Journal of Affective Disorders*, *277*, 347-357. https://doi.org/10.1016/j.jad.2020.08.034

Shreffler, J., Petrey, J., & Huecker, M. (2020). The Impact of COVID-19 on Healthcare Worker Wellness : A Scoping Review. *The Western Journal of Emergency Medicine*, *21*(5), 1059-1066. https://doi.org/10.5811/westjem.2020.7.48684

Travadon, N. (2020, mars 25). *Coronavirus "On nous envoie au casse-pipe » : Le coup de gueule des infirmiers de Normandie [Coronavirus. « We're being sent on a wild goose chase » : The grievance of Normandy nurses]*. Ouest France. (https://www.ouest-france.fr/sante/virus/coronavirus/coronavirus-entretien-nous-envoie-au-casse-pipe-le-coup-de-gueule-des-infirmiers-6791242

Van Steenkiste, E., Schoofs, J., Gilis, S., & Messiaen, P. (2022). Mental health impact of COVID-19 in frontline healthcare workers in a Belgian Tertiary care hospital : A prospective longitudinal study. *Acta Clinica Belgica*, *77*(3), 533-540. https://doi.org/10.1080/17843286.2021.1903660

Vanhaecht, K., Seys, D., Bruyneel, L., Cox, B., Kaesemans, G., Cloet, M., Van Den Broeck, K., Cools, O., De Witte, A., Lowet, K., Hellings, J., Bilsen, J., Lemmens, G., & Claes, S. (2021). COVID-19 is having a destructive impact on health-care workers' mental well-being. *International Journal for Quality in Health Care : Journal of the International Society for Quality in Health Care*, *33*(1). https://doi.org/10.1093/intqhc/mzaa158

WHO. (2023, août 18). *Clinical management of COVID-19—Living guideline*. World Health Organization. https://iris.who.int/bitstream/handle/10665/372288/WHO-2019-nCoV-clinical-2023.2-eng.pdf?sequence=1

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