

Burnout During Residency: A Thematic Analysis of Stressors, Coping, and Organisational Challenges Among Nursing Residents

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Abstract

Burnout is a pervasive challenge among healthcare professionals in training, with significant implications for both well-being and quality of care. This qualitative study, using a phenomenological design, explored the experiences of nursing residents regarding sources of stress, coping strategies, and organisational challenges, and how these factors contribute to the development of burnout. Three focus groups were conducted with 24 nursing residents. Data were analysed using reflexive thematic analysis. Five themes were constructed: peer solidarity as a protective shield, navigating institutional abandonment, the crushing weight of unmanaged demands, the “lottery of learning,” and the sacrifice of personal identity. Participants described residency as a demanding and disorganised stage, characterised by heavy workloads, inconsistent educational opportunities, and scarce institutional support. These conditions fostered emotional exhaustion and frustration, but peer networks were identified as a crucial protective factor, providing informal learning, solidarity, and resilience. The findings highlight the need for organisational reform in residency programmes, including greater educational equity, improved leadership, and spaces for dialogue and mentoring. Recognising the role of peer support alongside institutional responsibility can contribute to building more humane, sustainable, and ethically grounded training environments.

Keywords

burnout, residency training, family and community nursing, qualitative research, organisational culture, Spain

Resumen

El burnout es un problema generalizado entre los profesionales sanitarios en formación, con importantes repercusiones tanto en su bienestar como en la calidad de la atención. Este estudio cualitativo de diseño fenomenológico, explora las experiencias de los residentes de enfermería en relación con las fuentes de estrés, las estrategias de afrontamiento y los retos organizativos, y cómo estos factores contribuyen al desarrollo del agotamiento. Se llevaron a cabo tres grupos de discusión con 24 residentes de enfermería. Los datos se analizaron mediante un análisis temático reflexivo. Se construyeron cinco temas: la solidaridad entre compañeros como protector, cómo lidiar con el abandono institucional, el peso de las demandas sin gestión, la «lotería del aprendizaje» y el sacrificio de la identidad personal. Los participantes describieron la residencia como una etapa exigente y desorganizada, caracterizada por cargas de trabajo pesadas, oportunidades educativas inconsistentes y escaso apoyo institucional. Estas condiciones fomentaban el agotamiento emocional y la frustración, pero las redes de compañeros se identificaron como un factor protector crucial, ya que proporcionaban aprendizaje informal, solidaridad y resiliencia. Los resultados ponen de relieve la necesidad de una reforma organizativa en los programas de residencia, que incluya una mayor equidad educativa, un mejor liderazgo y espacios para el diálogo y la tutoría. Reconocer el papel del apoyo entre compañeros, junto con la responsabilidad institucional, puede contribuir a crear entornos de formación más humanos, sostenibles y con una base ética.

Palabras clave

burnout, residencia, enfermería familiar y comunitaria, investigación cualitativa, cultura organizativa, España

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Introduction

Burnout syndrome, recognised by the World Health Organisation (2019), is defined as a state of chronic occupational exhaustion resulting from sustained emotional and interpersonal stress in the workplace. In recent years, its prevalence has increased alarmingly among healthcare professionals. While this phenomenon affects the healthcare workforce globally, nursing professionals are particularly vulnerable due to the nature of their caregiving role, which involves constant exposure to suffering, high emotional demands, and increasingly complex work environments (Gómez-Urquiza et al., 2017; Molina-Praena et al., 2018). Burnout in nursing is specifically driven by an imbalance between high job demands—such as excessive nurse-patient ratios, shift work with consecutive days without rest, physical and emotional workload—and insufficient resources, including lack of professional autonomy, poor social support, and precarious employment conditions such as temporary contracts (Acea-López et al., 2021; Cañadas-De la Fuente et al., 2016; Dall’Ora et al., 2020; De la Fuente-Solana et al., 2019). For this reason, since 2022, burnout has been incorporated into the International Classification of Diseases (ICD-11) with the code QD85, under the name “work exhaustion syndrome.” This recognition emphasises the need to address psychosocial problems in the nursing workplace as a matter of priority.

Burnout in healthcare professionals manifests itself primarily through emotional exhaustion, feelings of professional ineffectiveness and depersonalisation (Maslach & Leiter, 2016; Molina-Praena et al., 2018). The consequences can be particularly serious, as they are associated with the onset of psychosomatic disorders, job dissatisfaction, absenteeism, suicidal ideation and even abandonment of the profession (Dyrbye et al., 2018; West et al., 2018). In the case of nurses, this situation can affect both their well-being and the quality of patient care. Burnout in nurses is associated with psychosomatic disorders, deterioration of mental health, job dissatisfaction, absenteeism, intention to leave the profession, and compromised patient safety (Ruiz-Fernández et al., 2020; Suazo Galdames et al., 2024). Additionally, nursing-specific consequences include compassion fatigue, reduced quality of nurse-patient therapeutic relationships, and

decreased capacity to provide empathetic care (Flowers et al., 2024; Sarabia-Cobo et al., 2021). Spanish studies have documented that nurses experiencing burnout report lower professional satisfaction, increased psychosomatic symptoms, and significant intentions to abandon nursing practice (Álvarez Gómez et al., 2019; Blanca-Gutiérrez & Arias-Herrera, 2018).

Nursing professionals experience significantly higher levels of burnout than workers in other sectors, with meta-analytic evidence showing prevalence rates ranging from 31% to 54% depending on the specialty and measurement tools used (De la Fuente-Solana et al., 2019; Molina-Praena et al., 2018). In Spain specifically, studies have documented high burnout prevalence among nurses, with emotional exhaustion being the most prevalent dimension, particularly among nurses working in critical care, emergency departments, and oncology services (Blanca-Gutiérrez & Arias-Herrera, 2018; Cañadas-De la Fuente et al., 2016; Gómez-Urquiza et al., 2017). This high prevalence in Spanish nursing has been associated with structural factors specific to the nursing profession, such as inadequate staffing levels, mandatory overtime, temporary employment contracts, limited autonomy in clinical decision-making, exposure to workplace violence, and the emotional demands of continuous patient and family advocacy (Acea-López et al., 2021; Pérez-Fuentes et al., 2018).

The transition from student to autonomous professional is a critical period, because professionals in training show even greater vulnerability to burnout (Zhou et al., 2020). Specifically, nursing residents—qualified nurses undertaking a formal, postgraduate specialisation programme—face unique challenges. In the context of this study, “nursing residents” refers to fully licenced nurses admitted through a competitive national examination to a 2-year, paid, full-time training programme similar to the medical residency model. These professionals assume progressive clinical responsibilities under supervision while completing an academic curriculum. This transition stage is often characterised by “transition shock,” where the clash between academic ideals and clinical reality generates significant psychological distress (Han et al., 2022). Recent Spanish research has confirmed that nursing residents face specific organisational stressors during their training period, including heavy workloads, role ambiguity between trainee and staff nurse, inadequate supervision, and

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limited institutional support, all of which contribute to elevated burnout levels (Chacón-Docampo et al., 2025). Moreover, the dual identity of nursing residents—simultaneously learners and care providers—creates unique pressures related to competency demonstration, academic demands, and rotational instability across different clinical settings (Chacón-Docampo et al., 2025).

Nursing residents face distinct stressors that differ from those experienced by medical residents, stemming from their dual role as both learners and frontline care providers. Unlike medical residents who progress through increasingly independent clinical responsibilities, nursing residents must simultaneously perform as fully licenced nurses delivering direct patient care while acquiring specialty competencies, creating sustained role conflict and workload stress during the first 6 to 12 months of practice (Halpin, 2015; Rainbow & Steege, 2019). The nursing residency stage is characterised by frequent rotations across clinical settings, pressure to demonstrate competence through periodic assessments, and variable quality of preceptorship and supervision—factors that contribute to fluctuating confidence and emotional exhaustion (Halpin, 2015; McNulty et al., 2022). Organisational determinants play a critical role: inadequate staffing, high workload, lack of effective feedback, and insufficient managerial support have been consistently identified as primary predictors of burnout among nursing residents and newly qualified nurses (Halpin, 2015; Rainbow & Steege, 2019; Riches et al., 2024). This transition period is further complicated by “transition shock” or “reality shock,” where the gap between academic preparation and the complexity of clinical reality generates significant psychological distress and elevated burnout risk (Halpin, 2015; Riches et al., 2024). Longitudinal studies have documented that nursing residents experience higher levels of compassion fatigue and secondary traumatic stress compared to experienced nurses, with these elevated levels persisting throughout the first year of practice (Flarity et al., 2018). In this context, within the framework of the project “Educational Intervention for the Development of Professionals Skills in Family Medicine and Community Nursing Residents (PROEMPATY)” (ClinicalTrials.gov Identifier: NCT04625582), burnout levels were assessed among family and community nursing residents in the Vigo Health Area (Spain), revealing high levels of burnout related to both personal and organisational factors (Chacón-Docampo et al., 2025), results consistent with international research documenting similar organisational and transition-related stressors in nursing resident populations (Flarity et al., 2018; Halpin, 2015; Riches et al., 2024).

Although there is extensive scientific research based on quantitative methods for measuring burnout in residents (Agarwal et al., 2020; Edú-Valsania et al., 2022), qualitative studies exploring the subjective experiences and perceptions of these professionals remain scarce. Unlike medical residents, whose burnout has been extensively studied, the specific

experiences of nursing residents remain under-researched. Existing studies on nursing burnout often focus on general staff nurses, overlooking the dual identity of the resident as both a worker and a trainee. This dual role introduces specific stressors such as academic overload, rotational instability, and the pressure to demonstrate competence in a new specialty. While some qualitative research has explored nurses’ lived experiences of burnout in general nursing populations, revealing themes of emotional exhaustion, compassion fatigue, and coping mechanisms (Flowers et al., 2024), the specific phenomenological experiences of nursing residents during their training period remain largely unexplored in the Spanish context.

Understanding the phenomenon from the perspective of family and community nursing residents can provide a deeper, more contextualised and human insight. While quantitative tools have measured prevalence, qualitative inquiry is needed to unpack the subjective experience of stress and coping in this specific group. Recent qualitative research has revealed that burnout directly compromises clinical training, generating what have been termed “necessary compromises” that affect motivation, teaching participation and perceptions of professional competence (Lu et al., 2021). Likewise, studies such as that by Odom et al. (2022), using participatory methodologies, have shown how residents develop personal and collective resilience strategies in response to the stresses of the training environment. In this sense, focus groups are an ideal technique for accessing shared experiences, the meanings attributed to discomfort, coping strategies and suggestions for improvement expressed by the residents themselves (Ironsides et al., 2019; Lewis-Beck et al., 2004).

Therefore, the objective of this study is to explore, through focus groups the experiences of nursing residents regarding sources of stress, coping strategies, and organisational challenges, and how these factors contribute to the development of burnout.

Methodology

Study Design

An exploratory qualitative study was conducted, based on abductive reasoning. The abductive approach was instrumental in interpreting the organisational dynamics observed, allowing for a theoretical integration of unexpected findings regarding collective resilience that a purely inductive approach might have overlooked.

This research was carried out under the interpretative paradigm focussed on reconstructing the meaning attributed to the phenomenon studied. A phenomenological perspective was chosen, given that the fundamental purpose of this study is to gain an in-depth understanding of how professionals in training—family and community nursing residents—construct, interpret, and assign meaning to their experience related to burnout syndrome. This perspective allows access

to the subjective world of the participants, capturing not only the objective facts, but also the perceptions, emotions, and meanings that emerge from their daily experiences. From this perspective, the focus is on unravelling how each trainee experiences the phenomenon, identifying the individual and collective nuances that shape their coping with the emotional, cognitive and organisational demands of their professional context (Smith, 2011; Smith et al., 2009).

The technique used for data collection was focus groups due to their ability to generate collective discourse that emerges from interaction between participants (Barbour, 2007; Kitzinger, 1995). This methodological choice is in line with previous research that has demonstrated the suitability of focus groups for exploring complex and experiential phenomena in the field of health (Tritter & Landstad, 2020). While interpretative phenomenological analysis traditionally focuses on individual accounts, focus groups were used to explore shared experiential reflections and collective sense-making within the nursing residency context (Palmer et al., 2010; Tomkins & Eatough, 2010).

The study was framed within a critical realist epistemology, which acknowledges the reality of the participants' experiences while recognising that their narratives are shaped by the social and organisational contexts of residency (Clarke & Braun, 2013). This approach allowed for a semantic analysis that captures the depth of the residents' discourses, aligning with the constructive and interpretative nature of reflexive thematic analysis.

The study protocol was approved by the Research Ethics Committee of Pontevedra-Vigo-Ourense (2020/153; Spain), within the framework of the PROEMPATHY project (NCT04625582), ensuring compliance with the ethical principles of qualitative health research, including informed consent, confidentiality, and protection of participants' identity.

Participants and Sampling Strategy

Purposive sampling was used to select participants who could contribute rich and diverse discourses regarding their experience of burnout during residency. This type of sampling is particularly suitable for qualitative studies focussing on complex and subjective phenomena, as it allows for the inclusion of profiles with direct experience and situated knowledge of the object of study.

The participants were 24 residents, divided into 3 focus groups. A sample of 24 participants was deemed appropriate, with no new significant themes generating in the final focus group. Residents from family and community nursing, attached to the Multidisciplinary Teaching Unit of the Vigo Health Area, participated, representing different years of training. This sample allowed for greater heterogeneity of experience and encouraged the emergence of shared meanings. The sample consisted of 24 family and community nursing residents. The participants' ages ranged from 24 to 32 years (Mean = 27.4; *SD* = 2.1). Regarding gender distribution, 87.5%

(*n* = 21) identified as female and 12.5% (*n* = 3) as male, reflecting the current demographic trend in the nursing profession in this region. All participants were in their first or second year of residency at the time of the focus groups. Regarding ethnicity, the sample was homogeneous, with all participants identifying as Caucasian/White.

The inclusion criteria were: being enrolled in the community nursing residency training programme at the time of the study, and having completed at least 1 year of training in order to contribute consolidated experience. Residents who were on extended sick leave or in external rotation during data collection were excluded. Participation was voluntary and unpaid.

Data Collection Procedure

The focus groups were held between May and June 2023 in neutral and accessible spaces within the healthcare facilities, ensuring the comfort and privacy of the participants and always with the authorisation of the person responsible. Each session lasted approximately 90 min and was led by a moderator with experience in qualitative methodologies, accompanied by an observer responsible for taking field notes and recording relevant non-verbal aspects. Neither of these individuals were part of the teaching team at the unit in order to minimise possible inhibitions in the discussions (Barbour, 2007; Tritter & Landstad, 2020).

The focus group guide avoided the direct use of the term "burnout" to prevent social desirability bias, focussing instead on the experiential dimensions of emotional exhaustion and organisational support to allow the phenomenon to be constructed from the participants' own narratives. Therefore, the guide was organised into three broad thematic blocks to facilitate a progressive exploration of the residents' lived experience: (1) sources of satisfaction and motivation in the residency (What has been the most positive aspect of the residency? Have you noticed any changes (for better or worse) over the years of residency? In what way has it changed?), (2) factors generating stress and emotional exhaustion (What has been your level of stress during the residency? How did the residency affect your life?, Have you experienced "financial stress," such as difficulty making it to the end of the month?), and (3) perceptions of the training received in coping skills (Did you use or do you use any strategies to avoid feeling stressed?, Do you think some type of service or activity should be incorporated to reduce stress levels among residents? Which one?). This guide was reviewed by experts in qualitative research and health training, and was previously piloted with a group of residents to verify its suitability and clarity. A semi-structured format was preferred over a completely open discussion to ensure consistency across the three focus groups and to manage the group dynamics, ensuring that the collective discourse remained centred on the core phenomenon of burnout while allowing unexpected insights to be constructed. These blocks

functioned as flexible “experiential prompts” rather than rigid categories, allowing the participants to anchor their narratives in specific phases of their residency while maintaining the inductive and open nature required by the phenomenological approach.

All sessions were audio recorded with the prior consent of the participants and transcribed verbatim by the research team. The transcripts were pseudonymised by assigning alphanumeric codes to each participant and removing any identifying information, in accordance with ethical recommendations for qualitative research (Goodwin et al., 2020; Orb et al., 2001).

Data Analysis. Data analysis was performed using thematic analysis, following the approach proposed by Braun and Clarke (2006, 2023). This type of analysis has made it possible to focus attention on meanings rather than signifiers. It was also a widely used strategy as an initial stage in various methodological approaches, as it allowed information to be organised through thematic classification. To this end, the data was categorised or coded in advance, which facilitates the development of a semantic analysis of topics at a later stage. This process was completed through a thematic review, aimed at identifying and exploring the relevant content that was generated from the participants’ discourse (Nowell et al., 2017; Tritter & Landstad, 2020).

The analytical process followed the six-phase recursive approach for reflexive thematic analysis: (1) Familiarisation through repeated reading of transcripts and recording reflexive insights; (2) Generating initial codes inductively, tracking both individual accounts and group interactions within the transcripts; (3) Constructing candidate themes by identifying shared patterns of meaning across the groups; (4) Reviewing themes against the entire dataset to ensure interpretative depth and consistency; (5) Defining and naming themes to capture the latent essence of the residency experience; and (6) Producing the final report.

Data adequacy was determined by the principle of information power (Malterud et al., 2016), rather than saturation, considering the study’s specific aim, the high specificity of the nursing resident population, and the richness of the dialogue generated in the focus groups. The analysis was an iterative and collaborative process where researchers engaged in reflexive dialogue to build insights and enhance understanding, rather than seeking a realist consensus. Group dynamics, such as moments of collective validation or shared frustration, were integrated into the interpretation using field notes.

The findings represent a constructed interpretation of the residents’ experiences, presented with illustrative quotes to maintain transparency and fidelity to the original discourse, in line with the epistemological positioning of the study (Braun & Clarke, 2006; Clarke & Braun, 2013). Special care was taken to include representative literal excerpts, duly anonymised, in order to illustrate the identified themes and preserve the expressive richness of the original discourse. Data were analysed in the original Spanish to preserve the

linguistic and cultural nuances of the participants’ discourse. Illustrative quotes were subsequently translated into English, ensuring semantic equivalence through a process of collaborative review among the authors.

Methodological Rigour

To ensure the trustworthiness of the study, several strategies were implemented (Bourgeault et al., 2010; Lincoln & Guba, 1985; Nowell et al., 2017). Credibility was established through researcher collaboration during the coding and thematic development process, involving continuous reflexive dialogue to build deeper insights. Furthermore, a reflexive journal was maintained by the moderator and observer to document potential biases and the researchers’ positioning. Transferability was enhanced by providing a rich, dense description of the context, while audit trails ensured the traceability of all analytical decisions. Finally, member reflections were conducted with participants to assess the resonance of the constructed themes with their lived experiences and to enrich the final interpretation. Collectively, these strategies strengthened the transparency and reliability of the research process, providing a solid basis for the subsequent discussion and practical implications.

Results

A total of 24 residents participated, divided into 24 focus groups, between May and June 2023. The sample included family and community nursing residents assigned to the Vigo Health Area. Different levels of training (from R1 to R4) and health centres were represented. This heterogeneity allowed for the collection of diverse and complementary discourses, as well as the identification of points of interprofessional and intergenerational agreement. Thematic analysis identified five major themes that structure the experiences shared by residents in relation to burnout during their specialised training period. These themes reflect both structural elements and relational and individual dynamics that condition the experience of discomfort, coping resources, and unmet training needs. The themes were as follows: (1) The protective shield of peer solidarity against emotional erosion; (2) Navigating institutional abandonment: The void of leadership; (3) The crushing weight of unmanaged demands: Normalising exhaustion; (4) The “lottery of learning”: Injustice as a driver of professional frustration; (5) The sacrifice of self: The boundaries between residency and personal identity. The identified themes, their definitions, and illustrative quotes are summarised in Table 1.

The Protective Shield of Peer Solidarity Against Emotional Erosion

One of the first elements that were developed spontaneously was the value placed on bonds between residents as a source

Table 1. Central Organising Concepts, Definitions, and Illustrative Quotes of Nursing Residents' Experiences.

Central organising concept	Description	Representative quote
The protective shield of peer solidarity against emotional erosion	Horizontal bonds that provide emotional safety and collective resilience in the face of institutional gaps.	<i>"For me, the positive thing is the people you meet. . . they support you a lot, they explain things to you, they look after you."</i> (Participant A)
Navigating institutional abandonment: The void of leadership	Perceptions of structural disorganisation and absent pedagogical leadership that foster a sense of vulnerability.	<i>"Often you didn't know who to ask. There was a kind of hierarchical chain, but you didn't know where to start."</i> (Participant F)
The crushing weight of unmanaged demands: Normalising exhaustion	Physical and mental depletion caused by the overlap of clinical and academic tasks and the normalisation of overexertion.	<i>"In the morning you were at the centre, then you had a course, and then tasks. You had no life. I lived for the residence."</i> (Participant M)
The "lottery of learning": Injustice as a driver of professional frustration	Disparities in the quality of tutoring and resources that lead to arbitrary and inequitable learning experiences.	<i>"There were people who had very involved tutors and learned a lot, and others who went to the centre and were ignored. It was a lottery."</i> (Participant A)
The sacrifice of self: The boundaries between residency and personal identity	The difficulty of setting boundaries, resulting in the postponement of personal projects and self-care.	<i>"I felt that the residency sucked all my energy. I had no space for anything else. No partner, no hobbies, nothing."</i> (Participant S)

of emotional support, informal learning, and a sense of belonging. In a context described as demanding and uncertain, the peer group became a space for shared identification and mutual support, particularly valuable given the lack of institutional support.

From the beginning of the focus group, several participants highlighted that the most positive aspect of the residency had been the opportunity to share the environment with highly valued professionals, referring both to colleagues in the same year and to senior residents who served as mentors or role models: "For me, the positive thing is the people you meet. Both the junior residents and your senior residents. . . they support you a lot, they explain things to you, they look after you, I don't know. That's the most positive thing I take away from it." (A)

This horizontal support becomes particularly valuable in times of emotional overload, institutional disorganisation or educational confusion. In the absence of clear role models or structured support, peer networks become the main source of guidance and support: "If it weren't for my colleagues, I would often have felt completely lost. It's like we figure things out together, even how to survive certain rotations or deal with certain tutors." (S)

In addition to emotional support, residents also highlighted the educational value of these bonds, which allow them to share practical strategies, academic resources, and advice for dealing with clinical or administrative situations. This informal but constant form of peer learning reinforces group cohesion and fosters a sense of community: "I learned many things from the senior residents that they don't teach you in the courses. . . practical things, tricks, how to talk to patients, how to command respect. No one else tells you that." (F)

There was also evidence of recognition of peer support as a mechanism for resilience in the face of work pressure and as a safe space to express discomfort, share frustrations or

simply let off steam: "Sometimes what saved you was leaving the centre and talking about it with a colleague. Even if there was no solution, at least you said it and didn't have to swallow it alone." (J)

Overall, this first theme reveals that, in an environment marked by structural tensions and training deficiencies, support among residents is a key resource for collective resilience, which not only mitigates emotional exhaustion but also allows for the construction of shared meanings about the residency experience.

Navigating Institutional Abandonment: The Void of Leadership

The participants reported a shared experience of lack of leadership and institutional disorganisation, especially with regard to rotation planning, task allocation and training provision. The perceptions gathered suggest an unstructured environment, with changing decisions, poor communication and a persistent feeling of lack of coordination, contributing to widespread unease and a perception of vulnerability.

One of the most frequently mentioned aspects was the improvisation in the organisation of training activities. Residents stated that courses and rotations were announced at short notice, without the possibility of prior planning. From their perspective, this dynamic made it difficult to organise their personal lives and balance their workload: "You didn't know when you were going to have a rotation or a course until they suddenly told you. And if you already had things planned, you just had to make do as best you could." (S)

Added to this situation was the difficulty of identifying clear channels of communication to address the improprieties arising from training activities. Residents said that, at times, they did not know who to turn to or what channels to use to resolve doubts or deal with situations of uncertainty.

This lack of clarity in communication generated discomfort and reinforced a perception of limited organisational support: “Often you didn’t know who to ask. There was a kind of hierarchical chain, but you didn’t know where to start. You went from one person to another.” (F)

In addition, institutional decisions were perceived as unilateral, lacking transparency, and without real opportunities for resident participation. This dynamic contributes to the feeling of not being listened to and, at times, to learned resignation: “We gave our opinions, but in the end, you felt that everything had already been decided. So why bother talking?” (M)

The group also engaged in critical reflection on the type of pedagogical leadership that existed, especially in relation to those in charge. Although some residents mentioned tutors who were involved and approachable, the most frequent reference was to figures who were absent, distant or “overwhelmed,” with little availability for real training support: “My tutor was fine, but you could tell she had too much on her plate. So even if she wanted to, she couldn’t follow up as she was supposed to.” (A)

These shortcomings not only impacted the quality of clinical training, but also the emotional experience of residents, who felt neither recognised nor supported. The lack of operational and pedagogical leadership thus becomes a structural factor which, according to the discussions, fuels emotional exhaustion and reinforces an organisational culture based on a lack of accountability: “Everyone passed the buck. No one said, ‘This is my job’. They just passed the buck” (V).

Throughout the focus group, the expression of these experiences generated moments of collective agreement, mutual validation and a certain shared indignation. The account of institutional disorganisation does not appear as a one-off complaint, but as a sustained experience that directly influences the perception of residency as an unstable, uncertain and emotionally demanding stage.

The Crushing Weight of Unmanaged Demands: Normalising Exhaustion

One of the most frequently mentioned issues throughout the focus group was the feeling of physical and mental overload associated with the work dynamics during the residency. The residents described excessive working hours, an accumulation of clinical and academic tasks, a lack of breaks, and constant demands that hindered both meaningful learning and personal well-being.

The overlap of healthcare responsibilities with compulsory courses or training activities was identified as a constant source of stress. It was not just the amount of work, but the lack of coordination between the different demands of the training programme that led to a feeling of distraction and exhaustion: “For me, the worst thing was that everything was in the afternoon. In the morning you were at the centre, then you had a course, and then tasks. You had no life. I lived for the residence.” (M)

This non-stop schedule created a feeling of constant saturation, which not only affected performance but also emotional state and perception of personal effectiveness. Some residents used terms such as “stress,” “anxiety” or “burned out” to describe their daily lives: “There were days when I left the centre with my head foggy. I no longer knew if I had done well or badly, I just wanted to go to sleep.” (S)

Physical effects related to accumulated fatigue were also identified, especially towards the end of the second year. Sustained effort, without opportunities for recovery or support, was experienced as an individual burden that had to be managed alone: “I felt that if I didn’t organise myself, no one else would. You were constantly putting out fires, but you could never stop.” (A)

In this context, stress came not only from the volume of work, but also from constant uncertainty. The participants pointed out that the lack of advance information, last-minute changes and the feeling of improvisation increased the general unease, fuelling anxiety: “Sometimes the worst thing was not the work, but not knowing what was coming. Whether it was a course tomorrow, or a change in rotation. . . You lived with WhatsApp open, waiting for the next mess.” (V)

One issue that came up in several interventions was the difficulty in identifying clear boundaries between work and personal time, especially when training tasks (such as preparing cases, presentations or documentation) had to be done outside working hours. This extension of work into the domestic sphere was not experienced as a choice, but as an imposition accepted as part of the culture of residency: “They didn’t ask you directly, but you knew you had to get it done. And when did you do it? At home, at night, however you could.” (S)

Beyond academic or administrative considerations, this issue directly touches on subjective aspects that affect mental health and the experience of professional identity. The collective narrative conveys a residency experienced as a period of high demands in which overexertion seems normalised and rarely recognised.

The “Lottery of Learning”: Injustice as a Driver of Professional Frustration

The focus group discussion reflected a clear experience of inconsistency in the quality and accessibility of the training received during residency. Participants contrasted very diverse training situations between centres, teaching units and professional tutors, which created a perception of inequality that affected both learning and motivation.

Several comments pointed out that the quality of rotations depended largely on random factors, such as the assigned tutor or the health centre where the practical training took place. This randomness was experienced as a form of structural inequality that was difficult to anticipate or compensate for: “There were people who had very involved tutors and learned a lot, and others who went to the centre and were ignored. It was a lottery.” (A)

In addition to the disparity among tutors, significant differences were mentioned in terms of the content and focus of the courses offered. Some residents said that certain content was repeated without being updated, while other relevant topics were not addressed at all. This perception of a mismatch between what was offered and the real needs of the clinical environment caused frustration: “There were courses that were very basic or very theoretical, and they didn’t teach you what you needed for day-to-day work. In the end, you had to find out for yourself outside of work.” (M)

Faced with these shortcomings, several participants reported having undertaken external training independently, at their own expense and outside working hours. This individual search for training opportunities contrasted with the lack of consistent institutional proposals and highlighted an additional, unrecognised effort: “The most useful courses I took were the ones I found on my own, and often they weren’t even validated. But at least I felt like I was learning something that was useful to me.” (S)

Inequalities were also identified in relation to access to certain training resources, such as hospital rotations, teaching materials, and protected study time. The availability of these resources varied depending on the assigned centre and did not appear to be governed by formal criteria. This situation contributed to a feeling of arbitrariness and lack of control, with implications for the development of residents’ skills: “At my centre, we didn’t have access to anything digital, nor did we have time to review things. You did what you could, but you felt like you were falling behind.” (F)

The issue of inequality was also expressed in terms of institutional recognition. Some participants felt that, despite their effort and commitment, there was no clear system of monitoring or formative assessment to evaluate their progress or detect difficulties. The absence of structured feedback increased the feeling of isolation and lack of guidance: “No one told you if you were doing well or badly. You just carried on, hoping you weren’t making too many mistakes.” (S)

The disparity in experiences not only affects professional development, but also the construction of identity as residents. The lack of common criteria and minimum quality standards creates a sense of disorientation and vulnerability, and fuels constant comparisons between colleagues that reinforce feelings of injustice.

The Sacrifice of Self: The Boundaries Between Residency and Personal Identity

The difficulty of balancing residency with other aspects of life was a recurring concern in the group’s interventions. Participants described an experience of constant imbalance, where the demands of the training programme took precedence over personal time, affecting physical health, emotional well-being and relationships outside the workplace.

One of the most notable elements was the practical impossibility of disconnecting at the end of the day. The residency extended beyond clinical hours, invading personal space

with pending tasks, organising activities, and a state of constant alertness to possible changes or unexpected demands: “You went home with your head full, thinking about everything that still needed to be done. You couldn’t switch off for a minute.” (V)

This difficulty in setting boundaries was also linked to a lack of autonomy over one’s own time. The residents recounted how institutional decisions about courses, evaluations, or meetings were communicated at short notice and without room for negotiation, forcing them to constantly reorganise their personal lives: “There were weeks when I had everything organised and suddenly a mandatory course would come up. You had to cancel everything, with no choice.” (A)

Throughout the group, several participants shared the feeling that they had had to postpone or give up important aspects of their personal lives during the residency. They mentioned emotional relationships, personal projects, or even life decisions such as motherhood, conditioned by the perception that there was no possible space to reconcile them with the demands of the programme: “I felt that the residency sucked all my energy. I had no space for anything else. No partner, no hobbies, nothing.” (S)

It was also evident that this burden was not only temporary, but was experienced as structural, integrated into a professional culture that normalised personal sacrifice as part of the training process. This model was accepted with resignation, but not without criticism: “They always tell you that residency is hard, that’s just the way it is. But no one questions whether it should be. We just accept it.” (M)

In some cases, residents described how they had tried to set certain boundaries to protect their personal time, albeit with difficulty and feelings of guilt: “Sometimes I decided not to go to a course if I was exhausted, but then you felt bad. As if you were less responsible.” (F)

The tension between professional involvement and preserving a life outside work was expressed as a source of silent exhaustion. Beyond the visible stress, the lack of space for rest, self-care and personal relationships creates a sustained scenario of vulnerability that runs throughout the entire residency period.

Discussion

The aim of this study was to explore the experiences of family and community nursing residents regarding sources of stress, coping strategies, and organisational challenges during residency. Our findings reveal that the experience of burnout in this population is fundamentally driven by an imbalance between high-pressure clinical environments and insufficient support structures, a dynamic that aligns with the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2017; Demerouti et al., 2001). Specifically, the results suggest that burnout is a constructed response to a pervasive sense of institutional abandonment and professional erosion. Nursing residents described a profound state of emotional exhaustion triggered by “job demands”—such as overwhelming workloads and the

overlap of clinical and academic tasks—which were not adequately buffered by “job resources” like effective pedagogical leadership or organisational mentoring. This experience is characterised by a “normalised fatigue” where personal identity is sacrificed for residency requirements, leading to professional ineffectiveness and emotional depletion (Maslach & Leiter, 2016).

One of the most recurring themes was the lack of leadership and institutional representation. Participants expressed the perception of an inaccessible structure, where decisions are communicated without transparency or dialogue, and where teaching figures appear distant or overwhelmed. The feeling of organisational abandonment is intensified in the case of nursing residents, who reported experiences of invisibility and hierarchical treatment. This absence of channels of communication reproduces a vertical logic that prevents the exercise of active educational agency.

This finding coincides with that proposed by Ironside et al. (2019), who link the lack of institutional representation with the weakening of the sense of belonging. Lu et al. (2021) also highlight that the limited availability of teachers impacts motivation and hinders the development of solid professional role models. From a critical perspective, these dynamics can be interpreted as manifestations of an institutional culture that prioritises operational efficiency over institutional support, with little room for mutual care or pedagogical listening.

The educational inequality between centres, tutors and available resources was another key factor contributing to the discontent. Residents identified notable differences in the quality of rotations, the usefulness of courses and access to materials, which leads to an arbitrary learning experience that depends on factors external to their own performance. This type of inequality violates the principle of educational equity and is linked to processes of disaffection, demotivation or excessive self-imposed demands (Brulin et al., 2023). Training institutions, as guarantors of quality training, must take on this challenge as a matter of ethical and organisational responsibility.

The account of excessive workload and lack of coordination between clinical and academic tasks reveals a training culture based on the normalisation of workload. Long working hours, overlapping compulsory courses and tasks outside working hours were described as everyday occurrences, accepted as an inherent part of residency. This model of sustained demands without effective recovery mechanisms has been widely linked to emotional exhaustion, deterioration of the work environment, and decreased clinical safety (Linzer et al., 2015).

Even more worrying is that this wear and tear is neither visible nor channelled, but rather encapsulated in what Alwatban et al. (2024) call a “culture of silence,” where suffering is internalised and avoided for fear of judgement or stigmatisation. This dynamic reinforces isolation and contributes to burnout, especially when there are no institutional

spaces for listening or emotional support. It is important to note that while some of the literature cited focuses on medical residents, their findings regarding stress and burnout provide a relevant baseline for comparison. However, readers should be mindful of the professional differences between medical and nursing residency profiles, as the specific clinical responsibilities and educational structures may vary.

In contrast, social support among nursing residents was considered as one of the few protective factors identified. Participants highlighted bonds between female peers as spaces for support, informal learning, and collective resistance in the face of uncertainty. Far from being anecdotal, these types of solidarity networks play a structural role in contexts where institutional support is weak. Odom et al. (2022) emphasise the importance of recognising these networks as legitimate forms of care and resilience, and propose their integration into training programmes through mechanisms such as peer mentoring, dialogue groups or collective tutoring.

Finally, the difficulties in balancing residency with personal life illustrate the subjective cost of the current model. Participants reported sustained sacrifices in terms of emotional ties, personal projects, and self-care time. This incompatibility between institutional demands and the vital needs of residents cannot be addressed as an individual problem of “time management,” but rather as a symptom of a training system that ignores the human dimensions of the professional process. As Shanafelt and Noseworthy (2017) warn, professional well-being is not a luxury, but a requirement for safe and ethical care.

The experience gathered in this study cannot be interpreted as a sum of isolated factors, but rather as the expression of a structural tension between the values that the residence should promote—learning, support, professional growth—and the material and institutional conditions that are actually offered. Recognising and addressing this tension is not only a matter of educational improvement, but also of organisational justice and commitment to the health of those who provide care.

Limitations

This study has some limitations. Participants were volunteers and were limited to a single teaching unit, which may restrict the transferability of the results to other educational contexts. In addition, group dynamics may have inhibited the expression of more critical or sensitive opinions. As this study was conducted in a single healthcare area, the results regarding leadership and organisational challenges should be interpreted with caution, as they may reflect local organisational culture rather than universal trends in nursing residency.

The pre-defined thematic structure of the focus group guide, along with the inclusion of specific prompting questions, may have subtly directed the participants’ discourse. While this structure ensured thematic coverage, it is recognised as a potential methodological constraint in the

spontaneous emergence of phenomenological meanings. Furthermore, the use of focus groups may have introduced social desirability bias, as participants might have moderated their criticism or filtered sensitive opinions in the presence of their peers. Although no comparative analysis by gender was conducted, the predominance of women in the sample reflects the demographics of the profession, and it was observed that expectations related to family caregiving may intensify work–life conflict in this group. However, the use of independent coding and researcher triangulation strengthen the data.

Implications for Practice and Training

The results reinforce the need to critically review the organisational models of teaching units, ensuring greater educational equity, better structural planning and genuine emotional support. Institutional strategies should include both structural changes (adjustment of workloads, standardisation of training) and relational interventions (mentoring, listening spaces). Actively incorporating nursing residents' voices into the evaluation and redesign of programmes can contribute to building a more equitable, humane and professionally sustainable training environment.

Conclusions

The family and community nursing residency, as described by the participants in this study, is characterised as a period of learning marked by structural tensions, inequality in training conditions and a lack of institutional support. Burnout does not emerge here as an individual response to overwork, but as the result of an organisational culture that normalises emotional precariousness, the invisibility of discomfort and the lack of accountability among teachers.

In the face of these conditions, the bonds between nursing residents prove to be a fundamental source of support: not only do they cushion the wear and tear, but they also allow for the creation of a collective sense of meaning, the sharing of informal knowledge and resistance to the fragmentation of the environment. Recognising the value of these community strategies involves shifting the focus from “individual care” to “institutional care” and from technocratic training to more humane, equitable and participatory models.

These findings invite us to rethink the design of nursing residency programmes from an ethical and organisational perspective, in which support, formative justice and recognition of discomfort are not peripheral elements, but central to the educational process.

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Ethical Considerations

The study protocol was reviewed and approved by the Research Ethics Committee of Pontevedra-Vigo-Ourense (CEIC 2020/153). All participants provided written informed consent prior to data collection. The research was conducted in accordance with the ethical standards of the Declaration of Helsinki and Spanish regulations on research. Confidentiality and anonymity were ensured throughout the study, and all data were de-identified prior to analysis.

Author Contributions

Macarena Chacón-Docampo: Conceptualisation, Methodology, Software, Formal Analysis, Investigation, Writing - Original Draft, Writing - Review & Editing; Ángela Asensio-Martínez: Conceptualisation, Writing - Original Draft, Writing - Review & Editing, Supervision; David Liñares: Formal Analysis, Investigation; Luis-Javier Márquez-Álvarez: Writing - Original Draft, Writing - Review & Editing; Marina Feijoo Barbeito: Investigation; Ana Clavería: Conceptualisation, Supervision.

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