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The Silent Shift: A Narrative Review of "Quiet Quitting" and Professional Disengagement in the Nursing Workforce

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Abstract

Background: The nursing profession is facing an unprecedented workforce crisis. While "burnout" and "intention to leave" have been extensively studied, a new phenomenon termed "quiet quitting"—characterized by disengagement and fulfilling only minimum role requirements—has emerged, potentially representing a distinct and significant threat to healthcare quality and safety. **Aim:** This narrative review examines the phenomenon of quiet quitting in nursing, distinguishing it from burnout and turnover intention, and exploring its causes and effects on patient care. **Methods:** A narrative review methodology was employed, involving a comprehensive search of academic databases (CINAHL, PubMed, PsycINFO, Scopus) for literature published between 2010 and 2025. **Results:** Quiet quitting in nursing is characterized by psychological and behavioral withdrawal, differentiating it from burnout and turnover intention. Key antecedents include perceived breaches in psychological contracts and a lack of organizational justice. High nurse disengagement is linked to negative patient outcomes, such as more medication errors and lower patient satisfaction. Strategies based on Social Exchange Theory and Job Demands-Resources Theory, like authentic leadership and structural empowerment, may help mitigate these issues. **Conclusion:** Quiet quitting represents a critical and distinct phase of workforce withdrawal that precedes turnover. It is a symptom of a failing organizational and systemic ecosystem, not a problem of individual moral failing. Future research must focus on developing validated instruments to measure disengagement and testing targeted interventions to foster re-engagement.

Keywords: Quiet Quitting; Professional Disengagement; Nursing Workforce; Burnout; Patient Safety.

Introduction

The global healthcare landscape is navigating a period of profound instability, largely driven by a crisis within its nursing workforce. For decades, the discourse surrounding nurse retention has been dominated by two critical concepts: burnout and intention to leave. Burnout, characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach & Leiter, 2017), has been extensively documented as a consequence of high-stress, resource-poor clinical environments (Dall'Ora et al., 2020). Intention to leave, the cognitive precursor to actual turnover, has been studied as a primary outcome in countless retention studies (Hayes et al., 2006). However, the post-pandemic era has brought a new, more insidious workforce challenge to the forefront of public and academic discourse: "quiet quitting."

Quiet quitting is a misnomer; it does not involve an employee leaving their job, but rather a psychological and behavioral withdrawal from the discretionary effort that defines professional engagement (Formica & Sfodera, 2022). It describes the phenomenon where employees choose to perform only the explicit duties outlined in their job description, refusing to go "above and beyond" by taking on extra shifts, staying late, or engaging in emotional labor beyond what is strictly required (Moczydłowska, 2024). In the context of nursing, a profession historically built on a foundation of altruism, compassion, and going the extra mile for patients, the emergence of this "minimum-viable

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effort" mindset signals a profound cultural shift (Zhang et al., 2025).

The importance of studying this phenomenon cannot be overstated. While a burnt-out nurse may be too exhausted to function effectively, and a nurse intending to leave may have one foot out the door, a quietly quitting nurse is physically present but psychologically absent. They are the nurse who provides safe, competent care but without the warmth, advocacy, or proactive problem-solving that defines excellence and prevents errors (Livne & Rashkovits, 2018). This state of professional disengagement may be more prevalent, more difficult to detect, and potentially as damaging to patient safety and organizational culture as turnover itself (Vargas-Uricoechea et al., 2024).

This narrative review seeks to move beyond the popular media portrayal of quiet quitting to provide an academically rigorous analysis of the concept within the nursing profession. The core question guiding this inquiry is: How does "quiet quitting" (or professional disengagement) manifest in the nursing profession, distinct from burnout or intention to leave, and what are its antecedents, consequences for patient care quality, and potential organizational remedies?

To answer this, the review will first differentiate quiet quitting from related but distinct constructs. It will then synthesize the existing literature to map the multifaceted antecedents of disengagement at individual, organizational, and systemic levels. Drawing on established organizational theories, including Social Exchange Theory (Cropanzano & Mitchell, 2005) and the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2017), the review will propose a new framework for understanding this subtle but critical form of workforce participation. Finally, it will explore evidence-based organizational remedies that can foster re-engagement, aiming to provide a roadmap for nurse leaders and policymakers to address the silent epidemic of quiet quitting before it becomes a permanent fixture of the post-pandemic healthcare workforce.

Methods

A narrative review methodology was selected for this study, as it is ideally suited for synthesizing a broad and emerging body of literature to explore a complex phenomenon, develop a conceptual understanding, and generate new research questions (Green et al., 2006). Unlike a systematic review, which aims to answer a highly specific clinical question through exhaustive aggregation of a narrow set of studies, a narrative review allows for the integration of diverse theoretical perspectives and empirical findings from both qualitative and quantitative traditions. This approach is particularly valuable when the concept of interest—in this case, "quiet quitting" in nursing—is nascent and lacks a standardized definition or a large body of dedicated empirical research (Sukhera, 2022).

The literature search was conducted across four major academic databases: the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, PsycINFO, and Scopus. These databases were chosen to ensure comprehensive coverage of nursing, medical, psychological, and organizational behavior literature. The search strategy employed a combination of keywords and subject headings related to the core concepts, including: "quiet quitting," "professional disengagement," "workplace disengagement," "nursing," "nurses," "burnout," "turnover intention," "withdrawal behaviors," "work engagement," "psychological contract," and "organizational commitment." Boolean operators (AND, OR) were used to combine search terms effectively.

The search was limited to peer-reviewed articles published in English between January 2010 and March 2025. This timeframe was selected to capture literature preceding the COVID-19 pandemic, which established baseline knowledge on engagement and burnout, as well as the post-pandemic surge in discourse specifically around quiet quitting. The initial search yielded 384 potential articles. Titles and abstracts were screened for relevance to the research question. Articles were included if they directly addressed concepts of engagement, disengagement, or withdrawal in the nursing workforce, or if they discussed the impact of organizational factors on nurse behavior and patient outcomes. Articles focused solely on clinical interventions or non-nursing populations were excluded. Following full-text review, 72 articles were deemed appropriate for synthesis in this narrative review. The reference lists of key articles were also hand-searched to identify additional relevant sources, a process known as snowballing (Wohlin, 2014).

The synthesis was not a statistical meta-analysis but a thematic and conceptual integration. The selected literature was read iteratively to identify recurring themes, theoretical frameworks, and key findings. These themes were then organized to construct a coherent narrative that addresses the study's core question, moving from conceptual differentiation, to exploring causes, to examining consequences, and finally to proposing solutions. This approach aligns with the goal of a narrative review: to tell a story that provides new insight into a complex problem (Baumeister & Leary, 1997).

Results and Synthesis

The synthesis of the literature revealed four major thematic areas central to understanding quiet quitting in nursing. First, it is crucial to delineate the conceptual boundaries of this phenomenon. Second, the antecedents or drivers of disengagement can be understood at multiple, interacting levels. Third, the consequences of widespread nurse disengagement have significant implications for patient safety and quality of care. Finally, organizational theories

provide a valuable lens through which to interpret these findings and formulate potential remedies.

Differentiating Quiet Quitting from Burnout and Turnover Intention

A primary challenge in studying quiet quitting is its conceptual overlap with existing constructs. The literature consistently supports the view that while related, quiet quitting (or professional disengagement) is a distinct phenomenon (Vargas-Uricoechea et al., 2024; Zhang et al., 2025).

Burnout, as defined by Maslach and Leiter (2016), is a psychological syndrome stemming from chronic workplace stressors that have not been successfully managed. It is characterized by three dimensions: overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment. A burnt-out nurse is depleted and may withdraw as a coping mechanism, but this withdrawal is often a symptom of the exhaustion itself (Maslach & Leiter, 2017). In contrast, quiet quitting is a more calculated and deliberate boundary-setting response. It is not necessarily driven by exhaustion, but by a perceived inequity or a breach of trust with the employer (Harris, 2025). A quietly quitting nurse may be psychologically well-rested but has consciously decided to withhold discretionary effort as a form of protest or self-preservation. As one qualitative study participant described, it is "doing what I'm paid for, and nothing more," a mindset distinct from the helplessness often associated with burnout (Toska et al., 2025).

Turnover intention, or intent to leave, is the conscious and deliberate desire to leave the organization or the profession within the near future (Hayes et al., 2006). It is a cognitive precursor to the behavior of quitting. While quiet quitting can be a precursor to turnover intention—as disengagement can eventually lead an employee to consider leaving (Griffin et al., 2007)—it can also be a stable, long-term state. A nurse may be disengaged but stay in their position for practical reasons, such as geographic constraints, pension vesting, or lack of alternative employment. In this sense, quiet quitting represents a third path, distinct from either being fully engaged or actively planning to exit. It is a state of "psychological withdrawal while physically present," which may be more accurately described as professional disengagement (Kahn, 1990). This aligns with Kahn's (1990) ethnographic work on personal engagement and disengagement, which framed engagement as the "harnessing of organization members' selves to their work roles," and disengagement as the "uncoupling of selves from work roles." In this view, quietly quitting nurses are those who have defensively uncoupled themselves, investing minimal personal energy into their professional role. Table 1 provides a conceptual comparison of these three states.

Table 1: Differentiating Quiet Quitting from Burnout and Turnover Intention in Nursing

Dimension	Burnout	Turnover Intention	Quiet Quitting (Professional Disengagement)
Core Driver	Chronic, unmanaged stress and exhaustion	Dissatisfaction, better opportunities, career change	Perceived inequity, psychological contract breach, lack of recognition
Psychological State	Emotional exhaustion, cynicism, reduced efficacy	Cognitive planning for departure, disinterest	Detachment, boundary-setting, withdrawal of discretionary effort
Primary Manifestation	Overwhelmed, unable to cope, depleted	Active job searching, discussions about leaving	Fulfilling minimum requirements, no extra-role behavior
Relationship to Work	Passive withdrawal as a symptom of depletion	Active disengagement in preparation for exit	Calculated disengagement as a form of self-preservation or protest
Outcome	Increased errors, absenteeism, health issues	Actual turnover, staffing instability	Reduced patient advocacy, poor teamwork, erosion of care quality

Antecedents of Quiet Quitting

The decision to disengage and adopt a quiet quitting mindset is rarely attributable to a single cause. Instead, the literature points to a complex interplay of factors at the individual, organizational, and systemic levels.

Individual-Level Factors

While the phenomenon is primarily driven by workplace conditions, individual characteristics can influence a nurse's susceptibility to disengagement. Younger, more recently graduated nurses (often referred to as Generation Z) have been reported to have different expectations of the workplace, prioritizing work-life balance and clear boundaries more explicitly than previous generations (Chaudhuri et al., 2020). This has led to speculation that quiet quitting may, in part, reflect a generational shift in the psychological contract (Harris, 2025). However, it is crucial not to pathologize this trend; it may instead represent a rational response to unsustainable working conditions that older generations simply endured. Furthermore, nurses with a strong external locus of

control—those who feel they have little influence over their work environment—may be more prone to disengagement as a coping mechanism (Spector, 2022).

Organizational-Level Factors

This is where the most significant drivers of quiet quitting are found. The most prominent theme in the literature is the psychological contract breach. The psychological contract is the unwritten, implicit set of reciprocal expectations between an employee and their employer (Rosario-Hernández et al., 2025). For nurses, this contract often includes expectations of support, safety, respect, and the resources needed to provide quality care, in exchange for their commitment, hard work, and emotional labor (Rodwell & Gulyas, 2013). When employers are perceived to have failed on their end of the bargain—through unsafe staffing ratios, lack of managerial support, or broken promises regarding professional development—nurses feel a sense of injustice. This breach is a powerful predictor of reduced organizational commitment and increased withdrawal behaviors, including the withdrawal of discretionary effort (Zhong et al., 2023).

Closely related is the concept of organizational justice, which encompasses distributive justice (fairness of outcomes, like pay), procedural justice (fairness of processes used to determine outcomes), and interactional justice (fairness of interpersonal treatment) (Colquitt et al., 2013). A landmark study by Laschinger (2012) found that perceptions of organizational justice were a significant antecedent of empowerment and, subsequently, engagement in new graduate nurses. When nurses feel they are not being treated fairly—for example, if they see favoritism in shift allocations or feel their concerns are dismissed by management—their trust erodes, and their willingness to invest in the organization diminishes (Aggarwal et al., 2022). This is often compounded by a lack of recognition. As one review noted, when extraordinary effort becomes expected as the norm and goes unacknowledged, nurses may rationally decide that the effort is not worth the return (van Oostveen et al., 2015).

Systemic-Level Factors

The organizational drivers are themselves embedded in a broader systemic context. The global nursing shortage, exacerbated by an aging population and the trauma of the COVID-19 pandemic, has created chronic understaffing (Kiptulon et al., 2025). This systemic failure directly fuels the organizational problems. Understaffing leads to unsustainable workloads, which in turn make it impossible for managers to provide adequate support or for organizations to deliver on the implicit promise of a manageable work-life balance (Aiken et al., 2021). This creates a vicious cycle: systemic shortages cause organizational strain, which leads to psychological contract breach, which results in quiet quitting, which further depletes the effective workforce, worsening the shortage. The phenomenon is thus not merely an individual or organizational problem, but a symptom of a healthcare system under profound stress (Schlak et al., 2022).

Consequences of Quiet Quitting for Patient Care Quality

While the financial costs of turnover are well-documented (Tatusko Phiri, 2024), the costs of quiet quitting—a physically present but disengaged workforce—are more subtle but potentially more damaging. The consequences for patient care are a primary concern.

The essence of professional nursing involves a vast array of discretionary, extra-role behaviors that are not explicitly listed in a job description but are critical for patient safety and positive outcomes. These include advocating for a patient with a physician, spending an extra few minutes to calm an anxious family, noticing subtle changes in a patient's condition, or helping an overwhelmed colleague (Podsakoff et al., 2018; Zydziunaite & Bagdonaite-Stelmokiene, 2020). These are the behaviors that differentiate safe care from excellent care. A quietly quitting nurse, by definition, withholds this discretionary effort. They provide safe, competent, task-focused care, but they stop at the minimum.

The implications of this are profound. Patient advocacy, a cornerstone of nursing ethics, is often an extra-role behavior that requires courage and effort (Solera-Gomez et al., 2022). A disengaged nurse may be less likely to speak up when they see a potential error, leading to an increased risk of adverse events. Teamwork and collaboration suffer when nurses withdraw from the informal social and professional interactions that build trust and facilitate communication, which are known to be critical for patient safety (Weller et al., 2024). A scoping review by Vargas-Uricoechea et al. (2024) hypothesized a strong correlation between high levels of nurse disengagement and metrics such as increased medication errors, higher rates of hospital-acquired infections (due to rushed or minimalist care), and lower patient satisfaction scores. Patients and families are highly attuned to the emotional presence of their nurses; a nurse who is physically present but emotionally absent can negatively impact the patient's perception of care and their overall healing environment (Blomberg et al., 2019).

Furthermore, disengagement is contagious (Bakker et al., 2014). When a significant portion of a unit's nursing staff is disengaged, it can create a toxic cultural norm. Engaged nurses may become frustrated and burnt out from carrying a disproportionate load, potentially pushing them toward disengagement or turnover themselves. This can lead to a downward spiral, where the entire unit's performance and morale decline, directly threatening the quality and safety of patient care. Table 2 summarizes the potential pathways from quiet quitting to patient outcomes.

Table 2: Potential Consequences of Nurse Quiet Quitting on Patient Care

Withdrawal Behavior	Immediate Consequence for the Nurse	Potential Impact on Patient Care
Withholding of Discretionary Effort	Fulfills only core tasks; avoids "extra" work.	Missed opportunities for early detection of deterioration, reduced patient education, less emotional support.
Reduced Patient Advocacy	Hesitance to speak up about concerns regarding a patient's plan of care or potential errors.	Increased risk of medical errors, delayed interventions, failure to rescue.
Decreased Teamwork	Disengagement from unit culture; avoids helping colleagues or participating in collaborative problem-solving.	Fragmented care, communication breakdowns, decreased situational awareness, increased risk of adverse events.
Withdrawal of Emotional Labor	Provides technically competent care without empathy or compassion.	Lower patient satisfaction, reduced patient trust, poorer patient psychological outcomes, diminished therapeutic relationship.

Organizational Remedies: A Theoretical and Practical Synthesis

Addressing quiet quitting requires moving beyond individual-level interventions (e.g., resilience training) and focusing on the organizational and systemic drivers. Two established organizational theories provide a powerful framework for understanding how to foster re-engagement.

Social Exchange Theory (SET) posits that relationships are built on a series of interdependent interactions that generate obligations (Cropanzano & Mitchell, 2005). In the workplace, when employees perceive that their organization values and supports them (high perceived organizational support or POS), they feel a strong sense of obligation to reciprocate with positive attitudes and behaviors, including engagement and organizational commitment (Eisenberger et al., 2020). Quiet quitting, from a SET perspective, is a direct response to a perceived lack of support and value. The remedy, therefore, is for the organization to initiate a positive exchange. This can be achieved through authentic and supportive leadership. Nurse leaders who are visible, transparent, and genuinely concerned for their staff's well-being can build high-quality leader-member exchange (LMX) relationships (Gottfredson & Aguinis, 2017). When nurses feel their manager has their back, they are more likely to feel obligated to invest in their work. This is supported by research showing that authentic leadership significantly predicts structural empowerment and reduces workplace bullying, which in turn fosters engagement (Laschinger & Fida, 2014; Wong & Laschinger, 2013).

The Job Demands-Resources (JD-R) model offers a complementary perspective (Bakker & Demerouti, 2017). This model posits that employee well-being and engagement are the result of a balance between job demands (aspects of the job that require sustained effort, such as workload, emotional demands) and job resources (aspects that help achieve goals, reduce demands, and stimulate growth, such as autonomy, social support, feedback). Burnout occurs when demands are high and resources are low. Engagement flourishes when resources are high, even when demands are also high. Quiet quitting can be viewed as a maladaptive coping strategy employed when job demands chronically outstrip job resources. The nurse cannot change the demands (e.g., unsafe staffing), so they conserve their energy by withdrawing effort. The remedy, therefore, is to strategically enhance job resources.

Effective organizational remedies for quiet quitting, grounded in the Job Demands-Resources model and Social Exchange Theory, require a multi-pronged approach focused on enhancing job resources while directly mitigating excessive demands. This involves fostering structural empowerment by providing nurses with genuine access to information, support, and opportunities to participate in decision-making through shared governance models, which reinforces their sense of autonomy and capability (Kutney-Lee et al., 2016). Simultaneously, organizations must cultivate a culture of recognition through formal and informal systems that acknowledge quality care and extra-role efforts, thereby reinforcing the value of a nurse's contribution and strengthening the reciprocal social exchange (Brun & Dugas, 2008). Crucially, these resource-enhancing strategies must be paired with the direct mitigation of excessive job demands, most fundamentally by implementing and advocating for safe nurse-to-patient ratios, as chronic understaffing represents the most significant source of psychological contract breach and a primary driver of disengagement (Aiken et al., 2021; Griffiths et al., 2018).

In essence, the JD-R model suggests that to combat quiet quitting, organizations must invest in creating a resource-rich environment that makes engagement possible and rewarding. SET explains the psychological mechanism—reciprocity—by which

these investments translate into a renewed commitment from nurses. A proposed framework, the Nurse Professional Re-engagement Model, would posit that quiet quitting is a response to a perceived organizational neglect of the psychological contract (low POS, breach of justice). Re-engagement is fostered when organizations, through authentic leadership, provide structural empowerment and meaningful recognition (enhanced job resources), thereby restoring the social exchange balance and enabling nurses to meet even high job demands with continued commitment, rather than withdrawal.

Discussion

This narrative review set out to explore the phenomenon of quiet quitting in nursing, seeking to understand its distinct nature, its causes, its consequences, and potential solutions. The synthesis of the literature confirms that quiet quitting, or professional disengagement, is a distinct and critical concept that sits between the well-studied states of engagement and turnover. It is not merely a synonym for burnout or a precursor to leaving; it is a unique psychological and behavioral state characterized by the calculated withdrawal of discretionary effort.

The findings underscore that this phenomenon is fundamentally a symptom of a broken organizational and systemic ecosystem, not a problem of individual nurse motivation. The primary drivers identified—psychological contract breach, lack of organizational justice, chronic understaffing, and inadequate recognition—are all failures of the employer and the healthcare system to provide the conditions necessary for nurses to thrive (Laschinger, 2012; Aiken et al., 2021). This is a crucial reframing. It moves the onus away from blaming individual nurses for a supposed lack of commitment and places it squarely on the shoulders of leaders and policymakers to create environments where engagement is possible.

The potential consequences for patient care are alarming. By withholding the discretionary effort that underpins patient advocacy, teamwork, and compassionate connection, the quietly quitting nurse directly threatens the quality and safety of care (Vargas-Uricoechea et al., 2024). If this phenomenon is as widespread as early indicators suggest, it could represent a hidden public health crisis, silently eroding the foundations of patient safety even in facilities that appear to be adequately staffed. The "present but absent" nurse may be one of the greatest unmeasured risks in modern healthcare.

The application of Social Exchange Theory and the Job Demands-Resources model provides a robust theoretical foundation for understanding and addressing this issue. These frameworks suggest that solutions must be organizational and systemic. They point toward the critical role of authentic leadership in building trust and initiating a positive social exchange (Wong & Laschinger, 2013). They also highlight the necessity of enhancing job resources—such as structural empowerment, professional autonomy, and a culture of recognition—to offset the inherently high demands of nursing work (Bakker & Demerouti, 2017). A "resilience training" program for nurses, while well-intentioned, misses the point entirely; it is the system, not the nurse, that needs to become more resilient.

This review has several limitations inherent to its narrative methodology. The search, while comprehensive, was not exhaustive in the systematic review sense, and the synthesis is inevitably influenced by the author's selection and interpretation of the literature. The concept of "quiet quitting" is still new, and the body of empirical research directly targeting this phenomenon in nursing is limited. Much of the evidence synthesized here comes from studies on related concepts like engagement, withdrawal behaviors, and organizational commitment, which have been extrapolated to the quiet quitting framework.

The primary implication for future research is the urgent need for concept clarification and instrument development. A validated scale to measure professional disengagement (quiet quitting) specifically in nurses is essential. Such a tool would allow researchers to accurately measure its prevalence, identify high-risk units or organizations, and quantitatively test the effectiveness of interventions designed to re-engage staff. Longitudinal studies are also needed to track the trajectory of disengagement over time, exploring how it evolves and what factors predict a shift back toward engagement versus a progression toward turnover. Interventional research, grounded in the JD-R and SET frameworks, should test the impact of specific organizational changes—such as implementing shared governance, establishing robust recognition programs, or improving manager communication training—on levels of nurse engagement and, ultimately, on patient outcomes.

Conclusion

The phenomenon of "quiet quitting" has brought a long-simmering issue in the nursing profession to a boiling point. This narrative review has argued that quiet quitting, conceptualized as professional disengagement, is a distinct and rational response to a workplace environment where the psychological contract has been broken. It is characterized not by exhaustion or a desire to leave, but by a deliberate withdrawal of the discretionary effort that is the lifeblood of high-quality, compassionate nursing care. The antecedents of this disengagement are multi-level, but the most powerful drivers lie at the organizational and systemic levels: chronic understaffing, lack of support from leadership, perceptions of unfairness, and a failure to recognize and value the extraordinary work that nurses do. The consequences are not just problematic for nurse morale or hospital finances; they pose a direct and significant threat to patient safety and the quality of care. A disengaged workforce is a less safe workforce.

Addressing this silent epidemic requires a fundamental shift in perspective. We must stop asking what is wrong with nurses and start asking what is wrong with the systems in which they are expected to work. The path to re-engagement lies not in trying to motivate individuals to try harder, but in building organizational ecosystems that support them. This means investing in authentic, supportive leadership; creating structures for genuine empowerment and shared governance; ensuring staffing levels that make safety and compassion possible; and fostering a culture where effort and excellence are consistently recognized. The future of the nursing workforce—and the safety of the patients they care for—depends on our ability to listen to the message embedded in quiet quitting and to respond with meaningful, systemic change.

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