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Understanding the Experiences Lived by Nurses Caring for Patients with COVID-19: A Hermeneutic Approach

Awatif Mansoor Alrasheeday

College of Nursing, University of Hail, Hail City 2240, Saudi Arabia, mshammari2022@gmail.com

Ma. Venus Borja

College of Nursing, University of Hail, Hail City 2240, Saudi Arabia, v.borja@uoh.edu.sa

Eddieson Pasay-an

College of Nursing, University of Hail, Hail City 2240, Saudi Arabia, e.pasayan@uoh.edu.sa

Farhan Alshammari

College of Nursing, University of Hail, Hail City 2240, Saudi Arabia, falshamarri@uoh.edu.sa

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Understanding the Experiences Lived by Nurses Caring for Patients with COVID-19: A Hermeneutic Approach

Awatif Mansoor Alrasheeday , Ma. Venus Borja , Eddieson Pasay-an* , Farhan Alshammari 

College of Nursing, University of Hail, Hail City 2240, Saudi Arabia

Abstract

Background: Nursing is highlighted among professions that value caring and is perceived as the profession's heart and soul because of its critical role in providing and delivering high-quality patient care, especially during this coronavirus disease 2019 (COVID-19) pandemic. However, little is understood about the experiences of the frontline workers in caring for persons diagnosed with COVID-19. This study aimed to explore the experiences of nurses in caring for persons diagnosed with COVID-19 inspired by the four lived worlds of van Manen.

Methods: The hermeneutic phenomenology was used in nine nurses working in hospitals of Hail region. This study employed a one-to-one interview approach using the Zoom platform, conducted between June and July 2020.

Results: Nine nurses articulated their experiences in caring for patients with COVID-19. Six themes emerged within the four lifeworld such as the feeling of vulnerability to COVID-19, time of uncertainties, price of being a hero, social stigma, holistic care, and sense of belongingness.

Conclusions: The feeling of vulnerability to COVID-19 infection, time of uncertainties, price of being a hero, social stigma, and sense of belongingness have been understood in the context of lifeworld existential of van Manen. Issues are articulated directly from those who experienced them. Still, revisiting the existing intervention strategies of the government and institution, including regulating negative emotions, reducing related issues, and improving quality of life, is important.

Keywords: COVID-19, emotions, hermeneutics, pandemics, quality of life

INTRODUCTION

Coronavirus disease 2019 (COVID-19) is a contagious and seemingly undefeated adversary that placed nurses as frontliners being highly vulnerable to infection. Recent studies have focused on risk management¹ and preparedness among healthcare workers during the COVID-19 pandemic.² However, little is understood about the experiences of these frontliners in caring for patients with COVID-19. In nursing, caring is considered fundamental, as it is perceived as the profession's heart and soul. Because of its critical role in providing and delivering high-quality patient care, nursing is highlighted among professions that value caring. Writers dating as far back as Florence Nightingale have expressed compassion as a notion inextricably linked to nursing work. Despite the numerous studies attempting to clarify what caring is,³ the idea remains unclear and vaguely understood.⁴ Caring is an emotion rather than a science that requires specific knowledge and skills.⁵ These are some reasons why several authors believe that caring is at the heart of nursing practice.⁶ Accordingly, caring is understood as a

multifaceted notion that may be characterized in various ways, depending on circumstances and points of view. Despite not being exclusive to nursing, caring is largely acknowledged as one of the profession's theoretical foundations.⁷ In such a context, caring for patients with COVID-19 brought many ambivalent feelings to nurses. This is true for those who have cared for patients with COVID-19, yet nurses' experiences in caring for these patients are not well-understood. Although the pandemic has increased the workload for nurses and created unpredictability, nurses still offered an effort to every patient with the same level of care that they had before the pandemic. The prioritization of nursing care was affected most likely as a result of the need for more basic care owing to the patient's high dependency and the development of new technical skills.

Nurses make up a large portion of the healthcare workforce during the COVID-19 pandemic and have been involved in diagnosing, treating, and caring for patients for weeks despite insufficient resources.⁸ Consequently, psychological discomfort such as depression and anxiety has been widely reported among medical personnel working on the front lines of the COVID-19 outbreak.⁹ Accordingly, the growing number of patients with COVID-19, increased workload, restricted availability of personal protective equipment, positive cases, and death stories in the media spread quickly. Furthermore, the lack of

*Corresponding author:

Eddieson Pasay-an
College of Nursing, University of Hail, Hail City, Saudi Arabia
E-mail: e.pasayan@uoh.edu.sa

appropriate treatment medications and assistance may add to healthcare workers' mental health problems.¹⁰

Important components of nursing care are expected to be universal; however, nurses' experiences are likely to differ throughout areas and countries because of major differences in the effects of the pandemic.¹¹ When caring for patients with COVID-19, nurses have demonstrated extraordinary resilience and adaptation, despite resource restrictions and mental and physical health hazards. Conversely, nurses require adequate support from their peers, supervisors, policymakers, and local community to properly prepare for and handle pandemic situations.¹²

To the best of the researchers' knowledge, no study has used a hermeneutic approach to examine the experiences of nurses when providing care for patients with COVID-19. To understand this, van Manen provides the four lifeworld existentials of lived body, lived time, lived space, and lived human interactions as starting points for contemplation on the world of lived experiences¹³ of these nurses. According to van Manen,¹³ the lived body is a term used to describe the bodily presence in our daily lives, as well as all experiences expressed, hidden, and shared through the lived bodies. One can think of time as an experience when referring to the existential of lived time. The lived time relates to the ways in which one experience the world on a temporal level and is made up of a subjective sense of time as opposed to the more objective or factual time. Time restrictions, liberties, and demands can affect how one feels, and vice versa. The existential lived space can be understood as the felt space, or the individual perception of the places people can find themselves in. Moreover, the lived space investigates how the environment can influence feeling and how emotions can alter how an individual see a certain environment. Finally, existential lived human interactions refer to the relationships that form and/or uphold with people in the lifeworld.¹³ In other words, the interactions and conversations with other people occur in the shared and created places and interactions with them.

This study aimed to explore the experiences of nurses in caring for patients with COVID-19 inspired by the lifeworld existentials of van Manen. While lived experiences of nurses caring for patients with COVID-19 were explored through different approaches, this study focused on the description and interpretation of the core elements of the lived experience and understanding of the practical significance of this experience. To explore the materials without imposing planned or predefined themes, van Manen's lifeworld existentials provided a coding structure. As a result, the existentials gave four areas through which the phenomenon under inquiry could start to be understood and investigated rather than imposed preset categories on the facts of what was judged significant to this lived experience. This was deemed crucial in maintaining methodological congruence and

remaining loyal to the exploratory and inductive nature of qualitative investigation.

These existentials give the researchers the opportunity to enter the lived experience of others and better understand the nature and importance of everyday experience. Therefore, phenomenological probing, thinking, and writing processes are productive phenomenological research categories for spatiality, corporeality, temporality, and relationality. Moreover, these existentials are a cogent and rigorous approach to analyze the relational, practical, and ethical aspects of everyday pedagogy that are challenging to reach through conventional research methods.

METHODS

Ethical approval

The Institutional Review Board of the University of Hail gave its clearance to conduct the study (H-2020-0214). The participants were informed of the importance and goal of the study, as well as other factors and their right to withdraw at any moment throughout the interview session. Participants' rights, anonymity, and confidentiality were always protected. The researchers emailed the informed consent form for the participants to sign. The signed informed consent was sent back to the researchers before the scheduled interview.

Study design

This study employed a hermeneutic phenomenology to explore the experiences of nurses in caring for patients with COVID-19 inspired by the four lifeworld existentials of van Manen.¹³ These lifeworld existentials guided the researchers in identifying significant statements and unraveling emerging concepts, thematic categories, and essential themes for every lifeworld. In this study, the research team had identified commonalities and shared structures in nurses' experiences of caring for patients with COVID-19 through the use of the lifeworlds, which made the more abstract elements of the participants' discussions more concrete.

Participants/sampling

The study participants were nine nurses (one male and eight female nurses) who have cared for patients with COVID-19 (Table 1). These nurses were recruited by snowball and purposive sampling, following the inclusion criteria: (a) had a direct contact and continuous care to patients with COVID-19, (b) had no signs and symptoms of psychological burden as a result of the experience in caring for patients with COVID-19 (for practical, ethical, and scientific considerations), (c) had cared for at least two patients with COVID-19, and (d) participated voluntarily.

Setting

This study was conducted in COVID centers of the Hail region, Kingdom of Saudi Arabia, particularly in the

intensive care units of King Khalid Hospital and King Salman Specialist Hospital. These hospitals were earlier identified by the Ministry of Health as COVID-19 centers of the region.

TABLE 1. Demographic characteristics of the participants

Code Name	Age	Sex	Nationality
Participant A	27	Female	Indian
Participant B	25	Female	Filipino
Participant E	28	Female	Filipino
Participant F	25	Female	Saudi
Participant H	31	Male	Saudi
Participant K	32	Female	Filipino
Participant M	28	Female	Indian
Participant R	24	Female	Filipino
Participant S	26	Female	Saudi

Data collection

Data collection commenced after clearance from ethics review board and hospital directors of each participating hospital. A personalized letter was sent to 15 prospect nurses, inviting them to participate in the study. The letter indicated that no incentives will be given to the participants for joining the interviews. Of the candidates, nine replied, expressing availability to participate. The researchers and participants agreed on the date, time, and mode of interview, which was conducted through Zoom meeting software, with the understanding that only the researcher and participant would be present in the meeting room. The one-on-one interview lasted 60–70 min and was recorded with the permission of the participants as discussed in the written informed consent and reiterated before the meeting.

The researchers used field notes. They used unstructured interview and/or interactive dialog for data collection. Sample questions included, “Can you describe to me your experience in caring for patients with COVID-19?” Sample probing questions included, “Can you further explain or clarify what you mean by that? Can you give an example?” Given the repetitive nature of data, researchers must determine the point at which saturation was observed. In this study, data saturation was reached on the seventh participant. However, two others were included to ensure data saturation. No repeated interviews were conducted. This study was conducted between June and July 2020.

The four researchers (two women and two men) were professors of the College of Nursing, held a doctor of philosophy in nursing degree, and were well trained in the interview process. The researchers’ reasons and interest in this research topic are propelled by their purpose of reaching a better understanding of the experiences of nurses caring for patients with COVID-19 so that tailored support can be given on time.

Narrative reflection

Participants’ stories provide a lens through which to view the evolving perspectives in caring for patients with COVID-19. We had to be careful as a researcher to distinguish between lived experiences and described experiences and prevent getting the wrong idea of causality. Although the stories may vary, participants’ identities stay the same; depending on how they respond to new problems, this fundamental identity may help or hinder them. Participants’ challenge may enlarge, improve, or affect them in ways that may not be visible to others but may be included into their story. Comparing some of the story examples was possible, which helped us understand how participants are affected by caring for patients with COVID-19. The researchers believed that while each narrative offered a complete picture of an idea. The stories may have been affected by our function as interviewers because we sought out details or elaborations. We encountered participants who were synthesizing their history, present, and future. The participants presented themselves in a specific way while sharing their stories, revealing or hiding aspects of themselves.

Measures to ensure rigor

In this study, researchers performed member-checking to achieve credibility. Participants were asked to read the verbatim transcripts of their respective interviews and provided feedback on the content. A detailed description of their experiences in caring for patients with COVID-19 was used to establish transferability. An inquiry audit or external audit was used to ensure dependability. The purpose was to evaluate the accuracy and evaluate whether the data support the findings, interpretations, and conclusions. Finally, to ensure rigor, a phenomenological study should have confirmability, which is obtained using audit trials to provide rationale and describe the thought processes behind the data collection, data analysis, and interpretation.

Data analysis

The researchers employed thematic analysis using NVIVO software (QSR International Pty Ltd., Burlington, MA, USA). The data analysis began immediately after the completion of the first transcriptions. Each researcher worked independently on the initial data analysis procedures, following predetermined steps. First, the researchers read the transcriptions and field notes for each interview numerous times to ensure a clear understanding. Then, phrases and expressions that described the experiences lived by nurses caring for patients with COVID-19 were chosen. Finally, meanings related to the experiences of the participants were generated. The researchers collaborated in group and organized the themes, and any discrepancies were resolved by re-evaluating the transcriptions and field notes until an agreement was reached. Subsequently, transcriptions were compared and analyzed for phrases that reflected similar theme descriptions. Then, themes were revised and described in greater depth. Statements

from participants who reflected each topic were chosen and rewritten. To this end, van Manen's four lived worlds were divided into key themes: lived body, lived time, lived space, and lived relations.¹³ All nine participants were requested to examine the findings (themes and descriptions) to ensure that the findings matched the information they had provided. The validation process revealed no discrepancies with the information given.

RESULTS

The essential themes of lived body, time, space, and relations were used to describe the experiences of nurses caring for patients with COVID-19. Results showed that five themes and one subtheme have emerged.

Theme 1. Feeling vulnerable to COVID-19

The participants discussed and described their bodies as vulnerable to coronavirus, and this includes everything they experience and feel as they care for patients with COVID-19. During their discussion and description, the theme "Feeling vulnerable to COVID-19" emerged. This theme pertains to the participants' emotional reaction accompanied by a level of uncertainty and entails a readiness to bear the psychological risk associated with the crisis.

When asked about their experiences in treating patients with COVID-19, nurses explained that patients were vulnerable to the infection. They felt that they are at a high risk, which affects them psychologically, emotionally, and physically. Most participants stated that caring for patients with COVID-19 were overwhelmed, making them afraid, cautious, threatened, hopeless, and exhausted. For example, one of the participants stated, "Our only concern is not to transmit anything to our family. That is why I had to isolate myself and was staying alone in the flat." (T)

Another reported:

"I am afraid that my body might contract the virus, especially when I am already tired. I think maybe they will have to reduce the off-duty time; instead of 12 hours, they would reduce it to 11 hours, or 10 hours just to help us. We cannot refuse the number of patients coming for treatment, especially because the service here is free." (M)

For some participants, the disease was very contagious as well as deadly, and they felt mentally exhausted because some of them appeared to experience COVID-like manifestations such as low-grade fever, severe headache, and cough. They felt that they are infected with the virus, fearing the unknown and feeling fatigued. The participants also feel physically exhausted when they had a tiring duty and experienced everyday fatigue. Moreover, their emotional state in taking care of patients with COVID-19 affects their emotions, as they will be isolated from their family as mandated by the hospital.

Theme 2. Time of uncertainties

As participants have been exposed to people who have the coronavirus for a longer period and are more likely to contract the disease, the theme "time of uncertainties" has evolved, suggesting that the participants' future is uncertain. The participants expressed their fear concerning such uncertainties regarding the time they might be infected. They thought that they might be the next patient and would not have the chance to live their lives fully (lived time). The participants expressed:

"I mean, I am here every day, and I think that by tomorrow I will be infected. Hence, you cease to plan for tomorrow. You live a wired life because you know anyway; any time you may be infected and gone." (E)

Moreover, the participants consistently exercised the right procedure to maintain a contagion-free workplace and, thus, expected to reduce the chances of being exposed to COVID-19. However, they question whether they will survive their duties given the uncertain situations. Participants continue to express anguish and anticipation of infection and continually think that long exposure to patients with COVID-19 will render them more susceptible to it. Two participants stated:

"Occasionally, you always think that maybe one day you will be infected, but I have no choice. I need to stay here and care for the patients because this is the profession I chose, and I pledged to serve the patients." (K)

"My family had lots of worries and doubts when they found that I am caring an infected individual, but I believe that there are no certainties in this situation. I just assured them that I do all precautionary measures so that I will not be infected." (M)

Theme 3. The price of being a hero

The price of being a hero and "social stigma" have emerged, representing the lived space. The theme "price of being a hero" refers to how participants feel despite their heroic actions; caring for patients with COVID-19 has made them feel distanced from their families, friends, and colleagues. Caring for patients with COVID-19 leads to becoming predisposed to spreading the virus, as the participants are likely to contract the disease.

"Other colleagues who were assigned to the ER were hesitant to talk to me like we talked about previously. Most of my friends were assigned to the ER. (...) When they came to the COVID isolation ward, they would just put the papers in a box and would not face us. They would go back and leave right away. (...) Feeling bad." (A)

Similarly, one participant mentioned:

"You met nurses on the way, and they would not even want to look in your direction or to meet you, or they would simply turn away and take another direction so that you would not recognize them. They would not

even allow you to greet them or spend some time discussing anything with them.” (L)

Being known as working in a COVID-19 unit creates fear that often clouds the understanding of colleagues and others. The fear of contracting the disease and not knowing how the disease is spread affect the perception of lived space. A participant stated: “They distanced themselves from us. Now I believe that caring for patients with COVID-19 shows how the nurse may experience a sense of separation.” (R)

Subtheme 1. Social stigma

The theme of social stigma refers to the prejudice of another person (e.g., colleagues and friends) toward the participants concerning a possible infection with the disease. Such prejudice has made the participants become distant from their colleagues, family, and friends, thereby acknowledging the limited space of the participants. That is, participants’ space (lived space) could not be shared with colleagues and others because of the fear of being infected with the disease and the unpredictability that surrounds the condition, enhancing vulnerability to the life-threatening malady. As a participant stated:

“You met nurses on the way, and they would not even want to look in your direction, or they do not want to meet you, or they simply turned away and took another direction so that you do not recognize them. They would not even allow you to greet them or spend some time discussing anything with them.”

The interpersonal environment that the participants experience as they discuss their care experiences of patients with COVID-19 depends on their relationships with other people. Participants understand and feel their interactions with others in this lived relationship. The “sense of belongingness” and “holistic care” were found to be two recurring themes in this lifeworld.

Theme 4. Sense of belongingness

The sense of belongingness (or passionate service) pertains to understanding participants’ experiences and recognizing that despite their struggles, humanity exists. This is without regard for his or her self amid the fear of contracting the virus. The participants still committed themselves to caring for others, especially those with COVID-19. The participants conveyed that they gave their selves to be with the patients who had contracted the virus. Their wholehearted service for others delineated a conscious giving of self in a planned relationship (lived relationship). In this situation, the participants deliberately dedicated themselves to caring for and being with the patients in uncertain conditions. The participants described their relationships with others as empathetic, inspiring them to be fearless and trusting. A participant mentioned:

“Caring for patients with COVID-19 needed a wholehearted service. One must be empathetic because I can only imagine myself getting the disease and feeling bad about it. Many questions were going on in my mind. I asked, “Who will care for these sick patients if we don’t?” I sympathized with them, giving me courage. Even though the nurses were accused of being COVID-19 nurses or dirty nurses, they had the empathy to continue their care for patients in COVID-19 isolation wards.” (R)

In addition, other participants shared their points of view, stating that:

“(…) if there is no teamwork, no one will survive in this pandemic. You cannot survive alone (H),” and that “(…) we will not be effective if we will not work as a team (…). Be mindful of our communication with our colleagues. How we need each other in duty.” (B)

One also stated that “(…) when you work with other colleagues, the thinking is less, and the work becomes easier as we help us in providing patient care (…). It is also psychologically healthy to have a colleague with you.” (H)

The participants recognize the sense of belongingness as a responsibility of professional nurses, realizing that patients with COVID-19 have the same rights to be cared for like anyone else. Additionally, the participants reported that they had to devote themselves to working hard in COVID-19 isolation wards.

Theme 5. Holistic care

Holistic care is a shared awareness of how nurses care for their patients with physical, psychological, emotional, and spiritual qualities. This is the provision of care and their relationship to patients based on a mutual understanding with the nurse to care for their physical, psychological, emotional, and spiritual dimensions (lived relation). Two participants refer to this by saying that “you can provide better service to the patients as you help each other, focusing on the whole aspect of the person” (H) and that “we provide comfort to our patients by praying with them and reassuring them that we are with them all the way.” (F)

Staying overtime in the isolation ward brought them closer together. They valued each other’s presence. The participants prayed with their patients. They continued to provide comfort, committed to caring, and give patients hope and reassurance despite the social distancing, wearing of full personal protective equipment, and handwashing. They also provided psychological support and extended financial help to non-Saudi patients. They trusted in the divine power to heal their patients and empower patients to care for themselves. Despite the uncertainties and different behaviors such as uncooperativeness and complaint, they still appreciated the value of the care that they provided to their patients. Indeed, they were very happy and felt that to discharge a

patient becoming negative for COVID-19 was very self-rewarding. Participants were cheering up each other for their present situation. A participant stated:

"It was very rewarding to us when we discharged patients in good condition. In fact, we cheered them up in support of their courage to beat the deadly COVID-19. This is because we do everything using humanism and holism as a guide to treating the patients." (S)

DISCUSSION

This study aimed to understand the experiences of nurses in caring for patients with COVID-19 using the lifeworld existentials of van Manen to gain deeper insights into the experiences of the participants as they battle with the coronavirus. Indeed, the discovery of new variants of the original coronavirus infection exposes healthcare providers to a new risk. Nurses feel vulnerable to the coronavirus infection in this context for being exposed to the disease. In this study, the feeling of vulnerability is just one of the challenges faced by these frontliners. Earlier studies have reported that many healthcare workers mimic COVID-19 symptoms, which makes them psychologically distressed. For example, similar concerns regarding contagion exposure and personal and family health have been highlighted among those caring for patients during H1N1 outbreaks.¹⁴ In this context, people's ability to deal with their emotions may be improved by cultivating adaptive views toward stress,¹⁵ helping alleviate negative physical symptoms, and improving physiological functioning. Findings such as the ones presented in this study emphasize the need to provide psychological support and prepare healthcare workers during the COVID-19 outbreak.

Participants accepted the situation while remaining fearful and concealed their anguish around patients during time of uncertainties. They triumphed in stabilizing their fears with the fulfillment obtained from caring for patients. Similar experiences have been eminent in other studies on nursing experiences during an upsurge of a disease.¹⁶ In Henan, China, nursing staff described the negative (e.g., fear and anxiety) and positive (e.g., confidence and happiness) emotions in COVID-19 isolation wards during their first week of exposure. However, after this period, 70% of the nurses had positive reactions.¹⁷ Such a result shows that these frontliners must receive continuous support from the institution and social assistance be made available to circumvent psychological disturbances, which could have a long-term negative effect on their mental health.

The price of being a hero has echoed among the participants as a result of their frustration for feeling excluded, despite being called the unsung heroes. These nurses put their lives on the line to save others and play a critical role in stopping the virus from spreading, yet they

have not received fair treatment in return. As expressed by the participants, their colleagues have rejected them, which made them feel their space tightening, which adds up to their psychological burden and harms their moral code. Previous study examined how actions that breach an individual's moral code or a sense of betrayal by others might cause the so-called moral damage.¹⁸ Moral damage has been recognized as a potentially major risk for healthcare professionals during the COVID-19 outbreak. Moreover, healthcare workers have shared experiences where they felt deceived by their colleagues and society, and this could be a risk factor for additional mental health issues, which can be dangerous during a pandemic.¹⁹ A greater understanding of this concern among frontliners could aid in the development of personalized interventions that effectively support the psychological health of these frontline workers.

Social stigma, being a subtheme in this study, marks the experiences of the frontlines on how colleagues and other individuals treat them for caring for patients with COVID-19. Accounts of nurses' caregiving experiences during earlier outbreaks of contagious illness are covered with references to societal stigma and its detrimental psychological effects.¹⁶ Indeed, nurses who cared for patients with COVID-19 have experienced stigma,²⁰ which may hinder the efforts of healthcare workers and health authorities to prevent COVID-19.²¹ In addition, most frontliners have had similar experiences. For example, nurses were not allowed to enter their rented housing, were not provided a house to rent, were not allowed to use public transportation having to rely on bicycles, and were attacked while on duty.²² The public's fear of being infected with COVID-19 is to blame for the disease's stigma.²³ Such stigma is characterized by misconceptions and negative attitudes against nurses and may impair the workforce and self-respect of healthcare personnel who provide support, treatment, and care to patients with COVID-19, potentially jeopardizing the prevention of COVID-19 outbreaks.²⁴

Amidst the fear of contracting the virus, the study participants are still committed to caring for patients and thereby promoting the sense of belongingness to humanity. Participants' caregiving experiences were also structured by their relations with patients and other members of the healthcare team. Most observations indicate that the sense of professional obligation is rooted in social and religious principles. Accordingly, nurses have formed a spiritual pledge to treat patients with COVID-19. Earlier studies have also reported that relationships with patients and other members of the healthcare team have shaped caregivers' caring experiences.^{16,25-27} Connecting socially with patients and advocating for their needs can give frontliners a sense of belongingness and add significance to their work. In this context, the study participants have demonstrated their professional responsibilities and ethical commitment to patient-

centered care. Moreover, participants reported that the pandemic made them recognize the value of professional solidarity and that they valued and supported one another more socially and psychologically because of the pandemic.²⁸ Thus, in this study, nurses showed the need for self-reflection as it helps them become more aware of nursing and caring, as well as the inner ethical principles in caring. This demonstrates that nurses will be able to get a better grasp of caring in their nursing practice.

In this study, the frontliners believed that holistic care must be delivered. Holistic care is the delivery of care to patients based on a mutual understanding between the patient and the nurse to address physical, psychological, emotional, and spiritual needs. The mental health, recovery rate, and satisfaction of patients with COVID-19 may all be influenced by holistic care.²⁹ Such care may be amplified at a low cost and benefit patients in both government and private health institutions. Indeed, this holistic care has also been echoed in India where nurses said they lacked a holistic COVID-19 approach to care. Owing to time constraints, the nurses claim that empathy and compassion-focused care, as well as listening to patients with COVID-19, are missing. Furthermore, there is no consensus in caring for and understanding patients.³⁰ Nurses' experiences in caring for patients with COVID-19 may be comparable with those in other settings, but administrative actions required may differ.

The use of van Manen lifeworlds as framework in this study stresses the peculiarities of the method. This method provides potential explanation for the phenomenon being studied. Therefore, a theoretical model, like the idea of the lifeworld existentials, provides a prism through which to investigate personal experience. In context, the use of this method provided us a way to start defining the different interrelated components that make up a specific lived experience.

This study contributes to the understanding of the experiences of frontline nurses during the surge of the COVID-19 pandemic and shows that nurse managers should focus on protecting nurses' well-being. By doing so, nurses can provide better and safer care performance and quality care that is expected of them.

This study has limitations that need further exploration in future studies. For example, the years of experience of these nurses were not a part of the inclusion criteria, and it might have implications concerning their experience in handling COVID-19. Moreover, the interview was conducted through a Zoom meeting where some of the visual cues were not fully observed.

CONCLUSIONS

The feeling of vulnerability to COVID-19, living in times of uncertainties, price of being a hero, social stigma, and

sense of belongingness have been understood in the context of lifeworld existentials of van Manen. The issues are articulated directly from those who experienced them. A need to revisit existing intervention strategies of the government and institution to include regulating negative emotions, reducing related issues, and improving quality of life are of paramount importance. In this contribution, the potential and unique value of the approach for pedagogical inquiry are demonstrated, together with certain methodological ideas and fundamental research practice tasks. Knowing nurses' experiences in caring for patients with COVID will eventually provide valuable information for future nursing care, not only those who were diagnosed with COVID but also those under similar life-threatening experiences.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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