

# The Experience of Frontline Nurses during the COVID-19 Pandemic: A Phenomenological Study

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## Abstract

The purpose of this phenomenological study was to describe the experience of frontline nurses working during the COVID-19 pandemic. The first author conducted two individual audiotaped interviews with 23 qualified staff nurses. All the authors analyzed the professionally transcribed data according to hermeneutic principles. The researchers identified five major themes: (a) we are family; (b) heroes work here; (c) fear of contagion; (d) mental health and well-being; and (e) new reality. Given the uncertainties of working during the COVID-19 pandemic, findings revealed the value of supportive collegial relationships and the need to support the mental health and well-being needs of frontline nurses during the pandemic. Nurses need supportive environments to help ease the challenges associated with serving on the frontline during times of crisis. Findings have implications for future public health preparedness and response efforts.

## Keywords

COVID-19 pandemic, nursing staff, qualitative research, burnout

Phenomenological studies describing the experience of staff nurses during the COVID-19 pandemic have been conducted in Canada (Nelson et al., 2021), China (Sun et al., 2020), Indonesia (Gunawan et al., 2021), Iran (Chegini et al., 2021; Radfar et al., 2021), and Italy (Arcadi et al., 2021; Simeone et al., 2022). Findings from these studies underscored the need for interventions that will assist nurses in addressing the emotional and mental health challenges associated with working during a pandemic (Arcadi et al., 2021; Chegini et al., 2021; Gunawan et al., 2021; Sun et al., 2020). Interventions are needed that will address the lack of access to adequate personal protective equipment and the burden of being considered a hero during a pandemic (Chegini, et al., 2021; Gunawan et al., 2021; Nelson et al., 2021).

Simeone et al. conducted one of the first phenomenological studies to describe the experience of nurses and physicians in Italy who became infected with the coronavirus while working. Sixteen participants (60% nurses) reported feelings of isolation, loneliness, fear of diagnosis, appreciation for the “touch of nurses,” and guilt of not being able to help colleagues. Researchers emphasized the importance of addressing the psychological outcomes associated with becoming infected during the COVID-19 pandemic (Simeone et al., 2022). Radfar et al. used phenomenology to describe the managerial and organizational challenges of nurses recovering from COVID-19 in Iran. Staff nurses reported

being treated differently than physicians or nurse managers, all of whom became infected with the virus. In addition, while issues such as interprofessional prejudice and insufficient resources for dealing with COVID-19 were problematic, recovering nurses noted positive aspects such as a stronger commitment to quality care, more awareness of nursing’s social role, and more appreciation for the humanistic aspects of care (Radfar et al., 2021).

Studies using phenomenology to describe the experience of nurses and nurse leaders working on the frontlines during COVID-19 in the United States, which provide a western context, are beginning to emerge (LoGiudice & Bartos, 2021; Robinson & Stinson, 2021; White, JH, 2021a). Findings from these studies highlighted the need to ensure the safety of self, colleagues, and loved ones (LoGiudice & Bartos, 2021), the

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value of maintaining human connectivity during a pandemic (Robinson & Stinson, 2021), and the discomfort associated with being referred to as a hero (Robinson & Stinson, 2021; White, 2021a). Some phenomenological studies have examined the experience of nurses in leadership roles in an acute care setting in the Mid-Atlantic United States (White, 2021b) and in Texas (Freysteinson et al., 2021).

Currently, there is a limited but growing body of literature that describes the experiences of nurses working during the COVID-19 pandemic. National and international studies have focused on a particular experience (e.g., nurses in leadership roles), a specialty, or a selected geographic region. Given the significant role frontline nurses play during any pandemic, we need an understanding of these experiences in order to address nurses' needs during a public health crisis. We sought to fill the gap in research about frontline nurses' experiences working on the frontline during the COVID-19 pandemic in the United States. Findings from such research are needed to help guide hospital leadership in strengthening nurses' preparedness and response efforts and provide the support that nurses may need during a pandemic.

### **Purpose**

Given the paucity of phenomenological studies with a specific focus on frontline nurses working during the COVID-19 pandemic in the United States, the aim of this study was to describe the meaning of the experience of frontline nurses working during the COVID-19 pandemic in an affiliated acute care and community-based setting during this time.

## **Methods**

### **Study Design**

Hermeneutic phenomenological research methods guided this study (Cohen et al., 2000). Hermeneutic phenomenological research is a combination of descriptive and interpretive methods. These methods, based on phenomenological philosophy, are used to determine how people interpret their lives and make meaning of what they experience. This emphasis on informants' experiences has been established as the best approach to understanding the experiences of others (Cohen et al., 2000; Geertz, 1973; Ricoeur, 1981). We used the phenomenological approach because its purpose is to understand the meaning of an experience from the perspective of persons who have had that experience (Cohen et al., 2000).

### **Sample and Setting**

The interviewer conducted open-ended interviews with a convenience sample of 23 nurses between January 2021 and July 2021. In total, 22 participants were staff nurses who delivered care at a Midwestern, 671-bed academic medical

center. The remaining participant was a registered nurse employed by the affiliated college of nursing as a community health nurse, a nonacademic or educator position, who provided COVID-19 screening and referral in a homeless shelter during the pandemic.

### **Protection of Human Subjects**

This study was approved by the Rush University Medical Center Institutional Review Board (approval #2006 1107-IRB01-AM03). In anticipation that nurses may become emotional when recalling their experiences, the interviewer informed nurses of their right to withdraw from the study at any time or not to respond to a particular line of questioning during the interview. Nurses were encouraged to follow-up with the Center for Clinical Wellness if needed; the interviewer did not make referrals to the Center during the study.

### **Data Collection and Analysis**

Before data collection, each investigator involved in the study performed "bracketing," which requires each researcher to write all pre-understandings, prejudices, and assumptions about the phenomenon. In Cohen et al.'s methodology, this is called the Critical Reflection Technique and helps investigators to be rigorous in analysis. In fact, phenomenological methodologies use an interpretative approach where researchers' own perspectives and historical contexts can make the accuracy of analysis contingent or something tentative. However, when researchers perform "bracketing," which is articulating their assumptions and beliefs about the phenomenon before data collection and analysis, they are more alert to subtle prejudices. Bracketing enhances the credibility of the data and analysis by reducing the chance that researchers will introduce their own biases rather than seeing the data from the participant's perspective. After bracketing, the first author, a female PhD-prepared Director of Nursing Research and Health Equity, conducted all of the interviews.

Using a system-wide listserv of all nursing staff, the interviewer sent all nurses an invitation to participate via the institution's intranet. The interviewer recruited and interviewed all participants. Interested participants shared their contact information (phone number and preferred email) with the interviewer so that she could direct them to a personal link to complete the informed consent and demographic form. They received a signed PDF copy of their informed consent. The interviewer assigned a unique study number to all consent and demographic forms that correlated with the transcribed interviews. All forms were stored on the REDCap server hosted by the medical center. Prior to the interview, the interviewer reviewed the consent form and allowed participants time to clarify or ask questions regarding the study. After receiving informed consent, the interviewer and participants arranged a time for the audio-recorded

interviews. The interviewer conducted two individualized audio-taped interviews via Webex, a system with audio and visual connection, to eliminate physical proximity/contact during the pandemic.

During interviews, the researcher asked participants open-ended questions. The use of an open-ended question is required in phenomenological research because it allows participants complete freedom in reporting their experiences. The participants' "world" becomes the focus of the investigation rather than topics chosen by researchers. The investigator had a welcoming attitude during the interviews (i.e., expressing cordiality and reassurance, not judging patients' storytelling, and being serene and smiling to facilitate participants' describing their experiences). During and after the interview the investigator took field notes on her own reflections, the setting, environment, and patients' body language. When participants seemed not to have anything further to say, the researcher asked them if they had anything more to add. If they did not, the interview ended. Data saturation, that is, the sampling to the point at which redundancy of the extracted themes is attained, was achieved after 23 interviews.

All interviews lasted from 30 to 60 minutes and were all digitally audio recorded. All interviews were open-ended, allowing participants to discuss their experiences related to serving on the frontline during the COVID-19 pandemic. The interviewer encouraged participants to describe their experience until they had nothing new to add. Interviews started with the following questions: (a) "What has it been like for you to work on the frontline during the COVID-19 pandemic? Please give me some examples to illustrate your work"; and (b) "What changes do you anticipate professionally, personally, or health care system-wide because of your experience?" The interviewer used probe questions to clarify descriptions or capture a more in-depth description of the individual's experience. Interviews lasted as long as the participant had new information to share, generally 30–60 minutes. Using the same approach, the interviewer conducted a second interview within approximately 30 days and shared the transcribed interview to verify content from the first interview and to see if participants had anything new to add or felt they had shared all that they wished to share during their initial interview. The interviewer conducted the interviews until the data were saturated, meaning no new themes emerged and themes became redundant.

### Data Analysis

Data analysis began during data collection. The authors did not use data analysis software. Field notes were used to augment transcribed interviews as needed. All authors conducted the phenomenological analysis by reading each transcribed interview several times, first to get a sense of the whole, and then line-by-line, highlighting phrases and identifying tentative theme names. The analysis was performed by each investigator. In the Cohen et al. methodology, researchers

first read each transcript several times to get a sense of the whole. Then, the researcher rereads each transcript line by line and starts to uncover a tentative notion of the meaning of an experience and labels passages with theme labels. In doing this, the researcher uses a reflective awareness that leads to dialectical examination of parts of the data to better understand the whole. When the whole is understood, different data or the same parts of the data are examined at a deeper level. Passages and themes from an interview are then compared with passages from other interviews.

To establish trustworthiness, a comparison of extracted themes was performed and discussed among all investigators in order to reach an agreement. We uncovered the meaning of the experience expressed by the nurse and used reflective awareness to further the analysis using dialectical examination of parts to better understand the whole. Thus, the authors completed the hermeneutic circle by first examining the whole transcript and then examining the parts and then back to the whole to see how they all fit (Cohen et al., 2000; Ricoeur, 1981). The authors clustered the verbatim comments according to similar themes and compared themes and passages across all informants. Procedures to ensure scientific rigor included validation of the codes and themes by discussion among the four researchers, two of whom were providing direct patient care and two of whom had extensive experience with phenomenological research. They discussed theme labels and passages and reached consensus. In addition, during the second interview, the nurses confirmed the beginning analysis.

The COnsolidated Criteria for REporting Qualitative Research (COREQ), a qualitative checklist for reporting qualitative research, was used when reporting these findings (Tong et al., 2007).

## Results

### Demographics

Most participants were female ( $n = 16$ , 70%), Caucasian ( $n = 15$ , 65.2%), between the ages of 25 and 40 years ( $n = 12$ , 52.2%), with a baccalaureate degree in nursing ( $n = 15$ , 65.2%), 11–20 years of nursing experience ( $n = 7$ , 30.4%), and were working on a COVID-designated unit ( $n = 15$ , 65.2%) (Table 1).

### Themes

Participants' experiences consisted of five major themes: (a) we are family; (b) heroes work here; (c) fear of contagion; (d) mental health and well-being; and (e) new reality. Here we present the identified five major themes.

*Theme 1: We are family.* Nurses reflected on their how relationships developed, deepened, and grew stronger, more like family during this time of crisis. Nurses viewed their

**Table 1.** Participant Characteristics (n = 23).

Participant Characteristic	n (%)
<b>Sex</b>	
Female	16 (70.0%)
Male	7 (30.0%)
<b>Ethnicity</b>	
Hispanic/Latinx	3 (13.0%)
Not Hispanic/Latinx	20 (87%)
<b>Race</b>	
Black/African American	4 (17.4%)
Asian	2 (8.7%)
Caucasian	15 (65.2%)
Native Hawaiian/Pacific islander	2 (8.7%)
Other	1 (4.3%)
<b>Generation</b>	
Baby Boomers (1946–1964)	2 (8.7%)
Generation X (1965–1980)	8 (34.8%)
Millennials (1981–1996)	12 (52.2%)
Generation Z (1997 onward)	1 (4.3%)
<b>Level of education</b>	
Associate degree in nursing	1 (4.3%)
Baccalaureate degree in nursing	15 (65.2%)
Baccalaureate degree non-nursing	2 (8.7%)
Master's degree in nursing	9 (39.1%)
Doctorate of nursing practice	1 (4.3%)
<b>Years in nursing</b>	
< 1 year	0 (0.0%)
1–5	4 (17.4%)
6–10	5 (21.8%)
11–20	7 (30.4%)
21–30	3 (13.0%)
31–40	2 (8.7%)
Missing	2 (8.7%)
<b>Type of unit</b>	
Designated COVID unit	15 (65.2%)
Specialty or mixed unit with some + COVID	7 (30.4%)
Homeless shelter	1 (4.3%)

relationships as central to their willingness to work during the pandemic as well as their level of comfort and ability to care for each other when providing nursing care to complex and high-acuity patients:

One of the biggest pros that developed from this pandemic was that I developed a community with some of my coworkers. I gained some friends in my department, that prior to COVID, you know, we were all friendly with each other, but we really didn't talk to each other outside of work were. And now we do all the time. So I felt like I gained some common ground and some sources or support that I didn't have before the pandemic.

Having more like, deeper compassion and understanding that my colleagues may be going through a rough time, during like pandemic, and always like checking up on them to make sure that they're okay, especially dealing with the end of life.

**Theme 2: Heroes work here.** While hospitals and health systems were declaring “heroes work here,” some participants reported that family and friends did not always value their sacrifice and professional expertise and knowledge. Some noted that after sharing their experiences providing care to very sick COVID-19 patients, some families and friends did not heed their advice about safety measures and the gravity of the pandemic. This led to feelings of moral distress:

I get an attack from a friend, a family member, telling me that I'm overreacting, or what I'm describing isn't real. “It's just the flu. I can still have this unnecessary party.” And you're interacting with people who don't understand the gravity of the situation and they're undermining what you're experiencing, and what you went to school for and that part of the ego of the nurse is the most trusted profession. . . . And you hear that “healthcare hero” terminology.

The notion that heroes work here had many dimensions, including administrative decisions around staffing and hazard pay:

so then we were still caring for COVID patients but no longer receiving the hazard pay. We had, you know, people would we would see these things on the Rush news alert saying we came to celebrate healthcare heroes. But my unit—the COVID unit—didn't receive any of this celebration of healthcare heroes. And so it just it felt very much like all of these celebrations occurred, not with us.

**Theme 3: Fear of contagion.** Participants frequently described personal fears of contracting the virus or spreading it to others. Protecting others, especially their families, was their highest priority. Nurses noted the challenges of donning and doffing as well as being uncomfortable while wearing PPE. They were making sacrifices yet often underestimated the importance of their sacrifices. They noted making both personal sacrifices with family and professional sacrifices to protect everyone from contracting the virus. One nurse noted using only one family car in order to limit any possible transmission of the virus to family members. Others noted delaying visits to loved ones as a means of protection:

It was physically exhausting. Because you're dressed to the nines, and PPE, and it can feel suffocating in some ways. Because when we're wearing the plastic isolation gowns, they're very hot, you're already wearing your regular clothes, and then this isolation gown and then your gloves, obviously. But then depending on the care the patient needs, you could be wearing a N95 or a surgical mask, then you're wearing your face shields. Many of us started wearing bonnets, so you're wearing a bonnet on top of your head. And then most of us wore our glasses instead of wearing our contacts.

Nurses sacrificed extra time to don and doff their PPE, taking away personal time after a long shift:

And I get to work and you have to change your shoes and put on your bonnet and all your PPE. But then at the end of the day, to mitigate any risk of me bringing COVID home, I would completely change all of my clothes, change my shoes. So that added an additional, you know, 20 to 30 minutes to my end of shift.

You worry so much that you will be the person that will get the people you love sick. And it is a weight I cannot fully describe. It is something that only, two weeks ago, three weeks ago, when I reached full immunization, that was the first time that I ever felt like I was not going to be the reason one of my family members passed away.

**Theme 4: Mental health/well-being.** The mental health and well-being of nurses during this time were concerning in light of staffing issues, frequent exposure to death and dying, and fear of the unknown. Some participants reported experiencing depression, anxiety, and elevated stress levels. These concerns prompted some participants to seek professional counseling or other proactive approaches to stress management, such as exercise, yoga, or using the resources from the medical center's Wellness Center:

Like one particular patient I took care of, and I was like, "Oh, he's doing great." Because then the next day, he was in ICU. And then the next following weeks he died. And well, you invest so much emotionally and physically, it takes a toll on you. I can't find anybody that can say mentally that they wasn't [sic] impacted by this.

I'm grateful for my church. I'm grateful for my family, that I had the opportunity when I feel sometimes like, "Oh, let me call somebody, I gotta get it out. I got to talk about it." I started seeing a therapist around that time, because I knew that this was a problem. I wasn't eating. So it was bad.

Another aspect of mental health was survivor's guilt or wondering why some became infected and the nurse did not:

What's so special about me? It was kind of like a survivor's guilt about it. After a while, I started referencing almost kind of a survivor's guilt. Because like, Why are my coworkers and why are these people getting sick? And why are some people dying, but I'm still okay, when I'm super exposing myself to hundreds of people? And to this day, I still never got it.

**Theme 5: New reality.** In order to maintain patient safety and provide quality care, nurses noted having to make a number of personal and professional adaptations when caring for patients and families. The adaptations to care delivery became the new reality for frontline nurses. In addition, some commented that caring for patients and families during this time added meaning to their service as nurses on the frontline:

Video calls, where the patient will be intubated and sedated a lot of times, and the family who's just like, on the video call, you set

it up, and then you just kind of, like leave it there. And they're just like, talking to their loved one, and crying and like missing them, and they can't be there. And it's just agonizing to watch that—it's horrible. And that was not, obviously, was not enjoyable as a nurse, but the times where you could in some way, like comfort a family over the phone, or just answer their questions or like more fully describe something that they hadn't understood. You know, or just talk with them. That was actually one of the most meaningful aspects of being a nurse.

Nurses also described wanting new work because of their experiences:

I think I don't want to work in critical care anymore. I think I might want to pursue ambulatory care, or I think this experience has made me really want to go back and finish school. I was actually looking for a different job in the early days of the pandemic.

I think for me professionally, I'm going to have to move on, you know, from emergency nursing, if I want to truly use my master's degree. I don't want to make a decision just purely out of frustration. I should be moving into something that I'm kind of excited about so for now, it's not that I hate my job. I mean, far from it, I still find meaning and purpose in my work.

Despite the challenges of serving on the frontline during a pandemic, some nurses reflected on the positive aspects of serving, such as a renewed confidence in being able to serve during a major infectious disease outbreak, being able to provide meaningful care to patients, and being able to build stronger collegial relationships.

## Discussion

This study is one of few phenomenological studies to describe the experience of frontline nurses working during the COVID-19 pandemic in the United States (LoGiudice & Bartos, 2021; Robinson & Stinson, 2021; White, 2021a). Other U.S. studies have focused on the experience of nurse leaders working during the COVID-19 pandemic (Freysteinson et al., 2021; White, 2021b), nurses' intent to leave their position or the profession during the COVID-19 pandemic (Raso et al., 2021) or the experiences of frontline nurses working during the COVID-19 pandemic in international settings such as Canada, Italy, Iran, and Indonesia (Arcadi et al., 2021; Chegini, et al., 2021; Gunawan et al., 2021; Nelson et al., 2021; Radfar et al., 2021). In the current study, working during the pandemic was a life-changing experience. The authors identified five major themes: (a) we are family; (b) heroes work here; (c) fear of contagion; (d) mental health and well-being; and (e) new reality.

In the current study, the theme "we are family" captures the feelings of camaraderie, connectivity, and support. The sense of family was positive and protective, bringing others closer during a time of crisis. The power of feeling connected was a major factor in deciding to come to work and support

coworkers. A phenomenological study of nurses working during the COVID-19 pandemic in Canada reported the value of team cohesiveness during the pandemic (Nelson et al., 2021). Similar to the current study, their participants grew closer over time enabling them to bring strength and comfort to each other. In a systematic review of the literature on working during a respiratory pandemic in countries outside of the United States, Fernandez et al. noted the value of professional collegiality in forming caring relationships, sharing the load, and encouraging team spirit (Fernandez et al., 2020).

Throughout the pandemic, nurses were hailed as “heroes” during one of the nation’s most defining health care crises in modern history. At the onset of the pandemic, celebrations were plentiful with recognition coming from within and outside of health care organizations. Participants commented on feeling supported and appreciated in light of the outpouring of support from hospital leadership and especially from the community at large. From food donations to diverse tokens of appreciation, most participants noted wonderful support from local businesses, the surrounding communities, and total strangers. Although participants expressed appreciation for such recognition, being viewed as a hero was troublesome when family and friends did not heed their professional advice or when administrative decisions placed an enormous amount of responsibility to take on additional duties in addition to providing patient care. The benefits and burdens of being considered a hero during the COVID-19 pandemic are not unique to our study. Similar to the current study, others confirmed these findings, noting that since nurses signed up for this type of work, this did not lend itself to being a hero (Robinson & Stinson, 2021; White, 2021a). Another study questioned the context of being a hero especially when nurses did not have adequate access to protective equipment (Gunawan et al., 2021). In the current study, although most participants felt personal protective equipment was adequately available, they noted exceptions in other outside work settings.

Most participants commented on the extreme measures they undertook to keep themselves, their loved ones, and others safe during the pandemic. The fear of contagion was palpable during the onset of the pandemic. Some suspended visits to loved ones and friends as one strategy to prevent infecting others. The ongoing use of safety measures such as changing clothes before entering one’s home was considered small sacrifices when it came to protecting loved ones from contracting the virus. Other studies, national and international, have reported similar concerns and measures relative to protecting self and others during the COVID-19 pandemic (Arcadi et al., 2021; LoGiudice & Bartos, 2021; Nelson et al., 2021).

The theme “Mental health and Well-being” during the pandemic continues to receive widespread attention. Throughout the pandemic, participants noted a number of stressors, including but not limited to staffing issues, fear of

personal contagion and infecting others, frequent encounters with death and dying, not being able to see loved ones as desired, and the first-time encounter with a pandemic, to name a few. In the current study, many participants mentioned seeking professional counseling to cope during these stressful times. These findings concur with previous studies that underscored the impact of stress, exhaustion, and fear of the unknown on the mental health and well-being of nurses during the COVID-19 pandemic (Arcadi et al., 2021; Nelson et al., 2021; Thompson Munn et al., 2021; White, 2021a). These findings suggest the ongoing need to assess for and intervene to support the well-being and resilience capacities among frontline workers (Thompson Munn et al., 2021). Such intentionality is critical to ensuring nursing retention and supporting all nurses regardless of years in the profession (Raso et al., 2021).

The feeling of survivor guilt, while not anticipated, was not surprising. Although not well documented in the nursing literature, especially during a pandemic, others have reported feelings of survivor guilt after the loss of a loved one, a traumatic event, or in clinical practice settings such as oncology (Hutson et al., 2015). Emotional fluctuations associated with serving as a frontline nurse and experiencing persistent and prolonged exposure to the virus but not becoming infected with the virus could be a precursor to these feelings or other manifestations of posttraumatic stress disorder. Nurses as well as nurse leaders and other senior leaders within health care settings should anticipate and acknowledge the full range of emotional responses when addressing the mental health and well-being of nurses working during any public health crisis.

The final theme, “new reality,” captures new perspectives regarding adaptations to care and care delivery as well as implications for nurses’ personal and professional futures. The finding that participants had to make adaptations to care during the pandemic is not surprising as new and existing infection control policies, staffing models, and other patient care guidelines were constantly evolving, especially early on in the pandemic. Adaptations to care were critical for protecting one’s self, patients, families, and other staff. Although participants in the study commented on having to do things differently, such as employing video conferencing to connect with families and serving as a surrogate for families, these adaptations became the new reality during the pandemic. Some noted learning new things about themselves and their ability to take on new and complex patient care responsibilities. One participant noted the benefits of self-reflection and the renewed sense of confidence after working on a different unit with a new patient population and care delivery model. Other U.S. phenomenological studies have reported, similar to the current study, that participants noted professional growth and a greater sense of confidence when providing care in the ICU during the pandemic (White, 2021a) and that nurses had great pride in serving as a nurse during the pandemic (LoGiudice & Bartos, 2021).

Regarding professional issues, some commented on the need to transfer to a less intense working environment such as ambulatory care. Others discussed the need to return to school for an advanced degree in nursing. Studies examining the impact of COVID-19 on professional careers are still unfolding. Raso and colleagues' study of nurses' intent to leave their position and profession during the COVID-19 pandemic found that of the 5,088 nurse respondents, 11% intended to leave their position and 20% were undecided (Raso, et al., 2021).

## Limitations

Nurses interviewed in this study worked in acute care and community-based settings while employed at a large academic medical center and college of nursing in the Midwest region of the United States. Nurses working in other settings or other areas of the country may have had other experiences. The PI conducted all interviews between January 2021 and July 2021, thus interviews captured one only point in time. Experience with the coronavirus, breakthroughs in treatments, the number of patients infected and dying, and the urgency to get people vaccinated continue to evolve. Thus, nurses' experiences with the pandemic are likely to change over time.

## Implications

The current study illuminated implications for supporting nurses working on the frontlines during the COVID-19 pandemic or subsequent infectious outbreaks. Although nurses in the current study demonstrated courage, collegiality, and adaptability, findings underscore the value in creating opportunities for nurses to dialogue about their experiences, in real time, during very stressful events. Study findings should be shared with health care administrators and leaders who are positioned to provide support and resources to frontline nurses during any public health crisis. At a minimum, nurses need access to PPE and related supplies in order to do their jobs and feel a sense of safety.

Given the stressful nature of working on the frontline during a pandemic, nurses must use resources to take care of themselves. While nurses have a natural tendency to care for others, taking care of themselves and using healthy coping strategies is a critical proactive step for supporting mental health and well-being. Along these lines, the public's referring to nurses as heroes, while not meant to harm, may result in unintended consequences such as delay in seeking mental health support or services or not taking time off to regroup to mitigate the stress or anxiety associated when serving on the frontline. This may be particularly important for new graduate nurses who have not developed the expertise or stamina to handle a crisis of this magnitude. Nurses need to know that other nurses have similar experiences.

Similar to other studies, nurses in the current study identified opportunities for future professional growth and

contribution due to their experience serving on the frontline. Health care systems should be of assistance in helping nurses to pursue new opportunities for growth and meaningful work in their respective institutions when possible.

Given their contributions to patient care and society as a whole during the COVID-19 pandemic, we need studies to explore how frontline nurses are embracing a new reality in nursing. Studies examining the impact of the COVID-19 pandemic on shaping professional nursing goals and desired practice settings, as well as longitudinal studies that examine the impact of serving on the frontline during a pandemic are fruitful areas of inquiry.

Public policies are critical to addressing the myriad of issues (e.g., nursing shortage, burnout, inadequate resources, staffing issues) that have emerged during the pandemic if we are to advance the profession and respond appropriately to the next public health crisis. We need public policies that will ensure that nurses have access to the essential supplies and wellness resources necessary to respond in a safe and efficient manner during any crisis. The need for public policies that address nursing workforce demand and supply will continue to be of importance. Such policies must support ensuring that we have a well-prepared nursing workforce who can respond to any future public health crisis as well as respond to any aftereffects of the COVID-19 pandemic.

In conclusion, the experience of nurses working during COVID-19 in this study is similar to that of nurses in other studies. The therapeutic value to the nurses describing their experiences in this study cannot be overestimated. Nurses in this study responded to COVID-19 with great resolve and commitment during an unprecedented time in our nation's history.

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## Ethical Approval

The Academic Medical Center's Institutional Review Board approved the proposal.

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## Supplemental Material

Supplemental material for this article is available online.

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