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Living on the Edge of Nothingness: A Heideggerian Hermeneutic Phenomenological Study of Nurses' Caring Under Bombardment

Mohammad Pourebrahimi
Baqiyatallah University of Medical Sciences
Saeid Hossein Oghli
Baqiyatallah University of Medical Sciences
Fatemeh Delfani
Baqiyatallah University of Medical Sciences
Zahra Mazhari
Baqiyatallah University of Medical Sciences
Morteza Ramezani
Baqiyatallah University of Medical Sciences
Milad Rezaiye
miladrezaiye73m@gmail.com

Baqiyatallah University of Medical Sciences

Research Article

Keywords: Nurses, Armed Conflicts, Qualitative Research, Existentialism, Attitude to Death, Spirituality, Grief, Terminal Care

Posted Date: November 23rd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11439428/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Armed conflict exposes nurses to direct danger while they sustain care for the wounded and dying. Existing research on nurses in war mostly catalogues stressors and coping, and says little about what caring means when nurse, patient, and family share one threat.

Aim

To interpret the lived experience of nurses who provided care under bombardment.

Methods

This qualitative study used Heideggerian hermeneutic phenomenology, operationalized through van Manen's approach. Six experienced nurses (12–25 years of experience; three women and three men) working in inpatient, emergency, intensive care, triage, burn/trauma and mobile relief settings were recruited through purposive sampling. Data came from in-depth, semi-structured interviews and were analyzed by moving repeatedly between parts and whole, from meaning units to codes, categories, and an overarching theme. Rigour followed Lincoln and Guba's criteria, and reporting followed COREQ.

Findings:

Six categories emerged, each read through a Heideggerian concept: existential fate-sharing with the patient (*Mitsein*), deliberate choice to remain under fire (*Entschlossenheit*), religious–spiritual meaning-making of care (*Sorge*), simultaneous conflict of multiple roles (*Geworfenheit*), repeated loss and witnessing of trauma (*Angst*), and redefining the aim of care from recovery to dignity (*Sein-zum-Tode*). Together they formed one overarching theme, *Living on the Edge of Nothingness: The Co-embrace of Existential Collapse and Existential Deliverance*. Collapse and deliverance were lived at the same time, not in sequence.

Conclusion

Nurses under bombardment experience their work as inseparably wounding and redeeming. Their care draws on shared fate, resolute choice and spiritual meaning, and it shifts toward dignified presence when cure is impossible.

Implications for practice:

Support should go beyond symptom reduction. It should protect time to process loss, prepare nurses for presence-based end-of-life care in crises, offer culturally grounded spiritual and peer support, and avoid measures such as cancelled leave that turn commitment into compulsion.

Introduction

Nurses are the backbone of health systems, yet a global workforce of 29.8 million still faces a shortfall of 5.8 million. About 70% of the projected 2030 shortage is concentrated in the WHO African and Eastern Mediterranean Regions (1). Armed conflict adds direct danger to this strain: WHO has documented more than 8,000 attacks on health care across 22 countries and territories since 2018 (2). Systematic evidence shows that war nursing involves practice challenges, the search for meaning, altered scope of practice, and a need for support (3), and recent wartime studies report substantial psychosocial burden among health workers and nurses (4, 5).

Iranian nurses bring a distinctive historical and contemporary experience. Oral-history research has documented their wartime service during the Iran–Iraq War (6), and the June 2025 12-day war again placed emergency nurses in the path of sudden urban warfare (7). Yet this literature is largely descriptive, cataloguing stressors, coping, and resilience through content or thematic analysis. What remains unexplored is what it means to care when nurse, patient, and family share a single threat, and mortality becomes immediate. This is an ontological question, well suited to Heideggerian hermeneutic phenomenology (8, 9). This study therefore aimed to interpret the lived experience of Iranian nurses providing care under bombardment.

Methods

Study design

This qualitative study used hermeneutic phenomenology grounded in Martin Heidegger's ontology (8), operationalized through van Manen's phenomenology of practice (9). In Heidegger's account, the phenomenon is not a pure essence to be recovered by suspending assumptions (Husserlian *epoché*). It is interpreted meaning, disclosed through being-in-the-world (*In-der-Welt-sein*). The approach fits our question: what does caring mean when nurse, patient and family are exposed to the same threat? The findings are treated as an interpretation shaped by the researchers' pre-understanding, made explicit rather than bracketed. Reporting followed the COREQ checklist (10).

Heideggerian inquiry treats the researcher's pre-understanding as the starting point of interpretation. Before data collection, the team recorded its assumptions about wartime nursing (professional, cultural and religious) in a reflexive journal. These were revisited during analysis to see how they shaped interpretation, and were not discarded. [Describe the interviewer's role, training in qualitative research, and any personal connection to the events.]

Setting and participants

Participants were nurses with direct experience of providing care during bombardment in Iran. Eligibility criteria were: (a) at least [10] years of clinical experience, (b) direct patient care during the conflict, and (c) willingness to describe the experience reflectively. Nurses currently in acute psychological crisis were not approached.

Purposive sampling with maximum variation was used across sex, experience, and clinical setting. Six nurses (three women, three men; 12–25 years of experience) took part, working in inpatient wards, an urban emergency department, a mobile relief base, intensive care, triage, and a burn/trauma unit.

A sample this size is consistent with phenomenological inquiry, which seeks depth of meaning rather than statistical representation. Adequacy was judged by information power (11): a narrow, well-defined aim, highly specific participants, an established theoretical frame, and rich interview dialogue. Recruitment stopped when further interviews were no longer deepening the interpretation.

Data collection

In-depth, semi-structured interviews were conducted in Persian, in private settings chosen by participants. Interviews lasted 45–90 minutes and were audio-recorded with consent.

The guide began with an open invitation ("Please tell me about a moment of caring for a patient during the bombardment that stays with you"). Probes explored lived experience, not opinion:

- being alongside patients in shared danger;
- the decision to stay or leave;
- what gave the care meaning;
- experience of time, competing responsibilities and priorities;
- encounters with loss and dying.

Follow-up probes ("What was that like?", "Can you describe a specific moment?") kept accounts concrete. The interview guide was developed by the research team specifically for this study and has not been published elsewhere. It was piloted with nurses and refined. An English version of the guide is provided as Supplementary File 1. Interviewers wrote field notes and reflective memos after each session.

Data analysis

Interviews were transcribed verbatim and analyzed in Persian to preserve meaning. Analysis followed van Manen's thematic approach within a hermeneutic circle, moving iteratively between parts and whole (12). Three readings were used:

- Holistic: each transcript was read to capture its overall sense.
- Selective: statements that stood out as revealing the experience were highlighted.
- Detailed: each transcript was examined line by line.

Text was divided into meaning units, condensed into codes, and grouped into categories. Categories were then interpreted against Heideggerian concepts and integrated into an overarching theme. Interpretation continued until the theme coherently accounted for the whole dataset, with the aid of MAXQDA. Quotations selected for reporting were translated into English by bilingual team members and checked against the Persian originals.

Trustworthiness

Rigour was addressed with Lincoln and Guba's criteria (13), adapted to a hermeneutic stance:

- Credibility: prolonged engagement with transcripts, independent reading by two researchers with discussion of divergent interpretations, and rich supporting quotations. Participants were given a summary of the interpretation to confirm resonance. Because the theme is an interpretation and not a description, this was a dialogue, not a demand for agreement.
- Dependability: an audit trail of analytic memos and the path from meaning unit to theme.
- Confirmability: a documented chain of evidence from transcript to theme, plus the reflexive journal.
- Transferability: thick description of context and participants, so readers can judge applicability to similar settings.

Results

Participants

Six experienced nurses (three women, three men) participated. Their clinical experience ranged from 12 to 25 years, and they had worked in inpatient, emergency, intensive care, burn/trauma, and mobile relief settings during the bombardment (Table 1). Quotations are identified by participant number (P1–P6).

Table 1
Demographic and professional characteristics of participants (N = 6)

ID	Sex	Years of experience	Setting during the crisis
P1	Female	18	Inpatient ward
P2	Male	22	Emergency department, urban hospital under bombardment
P3	Female	15	Mobile relief base
P4	Male	25	Intensive care unit
P5	Female	12	Emergency department, casualty triage
P6	Male	20	Burn and severe trauma unit

Overview of findings

Interpretive analysis yielded twelve meaning units, condensed into twelve codes and grouped into six categories. Through repeated movement between parts and whole, these converged on one overarching theme: **Living on the Edge of Nothingness: The Co-embrace of Existential Collapse and Existential Deliverance** (Table 2). Participants did not experience collapse and deliverance in sequence. Both were lived in the same moment.

Table 2
From meaning units to the overarching theme

Meaning unit (condensed)	**Code**	**Category** **(Heideggerian concept)**	**Pole**
The boundary between nurse and patient dissolves in shared danger	Collapse of the self/other boundary under shared threat	**1. Existential fate-sharing with the patient** (*Mitsein*)	Deliverance
Fate-sharing persists after the shift ends	Continued bond beyond place and time of service		
Staying is a free choice, not an external obligation	Authentic choice of professional identity over escape	**2. Deliberate choice to remain under fire** (*Entschlossenheit*)	Deliverance
Awareness of possible death gives the choice more meaning	Resolve held knowingly in the face of death		
Nursing is interpreted as worship and nearness to God	Care as worship/proximity to God	**3. Religious–spiritual meaning-making of care** (*Sorge*)	Deliverance
Religious meaning shields against psychological collapse	Faith as a psychological shield against trauma		
Patient, family and self-preservation are felt at once	Inseparable simultaneity of multiple concerns	**4. Simultaneous conflict of multiple roles** (*Geworfenheit*)	Collapse
Usual prioritisation breaks down	Collapse of temporal ordering of priorities		
Witnessing families' grief creates trauma of its own	Secondary trauma from witnessing others' grief	**5. Repeated encounters with loss and witnessing trauma** (*Angst*)	Collapse
Loss follows loss with no time to process	Accumulation of loss without room to grieve		
When cure is impossible, care shifts to presence and dignity	Shift from therapeutic goal to dignifying presence	**6. Redefining the aim of care from recovery to dignity** (*Sein-zum-Tode*)	Both poles
Dignifying the moment of death is the height of responsibility	Dignifying death as the peak of professional identity		
Overarching theme:		**Living on the Edge of Nothingness: The Co-embrace of Existential Collapse and Existential Deliverance**	

Category 1: Existential fate-sharing with the patient

Nurses described losing the usual distance between caregiver and patient once danger was shared. They no longer felt like outside helpers but like fellow sufferers. This bond persisted after the shift ended, as though they no longer breathed apart from their patients.

"I could no longer tell which of us was in greater danger, me standing beside the bed or him lying on it. It was as if we shared a single breath." (P1)

Category 2: Deliberate choice to remain under fire

Staying was described as an authentic act of will. Participants did not experience it as compliance or as ignorance of the danger. Knowing that death was possible sharpened the choice and gave it meaning.

"No one ordered me to stay. I could have left like many others. But something inside me said that if I left, I would no longer be the person I want to be." (P2)

Category 3: Religious–spiritual meaning-making of care

Participants interpreted caring as an act of worship and closeness to God. This meaning also sustained them, functioning as a protection against psychological breakdown in the face of trauma.

"My hand was on his wound, but my heart was with God. That touch brought me closer to Him than any prayer I had ever prayed." (P5)

Category 4: Simultaneous conflict of multiple roles

Concern for the patient, for the family at home and for one's own life arrived together, without order or priority. The habitual ability to decide "what first" gave way, and time itself lost its usual sequence.

"One hand was on the patient's pulse, part of my mind was with my children at home, and deep down a voice said this might be my last moment. All three at once, not one after another." (P1)

Category 5: Repeated encounters with loss and witnessing trauma

Nurses were burdened not only by clinical deaths but by witnessing the grief of bereaved families, a distinct trauma that lingered. Losses came in rapid succession, leaving no room to process or mourn.

"Watching a patient die was hard, but the sound of a mother wailing over her son still echoes in my ears at night." (P6)

Category 6: Redefining the aim of care from recovery to dignity

When rescue was no longer possible, nurses redefined their purpose as accompanying the dying so that no one died alone. This presence was experienced as the fullest expression of professional responsibility and identity.

"I could not save him anymore. I only held his hand and said, 'You are not alone.' That became the whole meaning of nursing for me." (P2)

Overarching theme: Living on the Edge of Nothingness

Taken together, the categories form a paradoxical whole. Categories 4 and 5 carry the pole of collapse. Categories 1, 2 and 3 carry the pole of deliverance. Category 6 holds both at once: in accompanying death, nurses met the most terrifying and the most liberating aspect of their existence in a single moment. The two poles did not cancel each other. Nurses lived them together, at the edge of nothingness.

Discussion

This study interprets the experience of nurses caring under bombardment as living on the edge of nothingness. Collapse and deliverance were not phases that followed one another. They were lived in the same moment. For Heidegger, such moments pull Dasein out of everyday absorption and confront it with its own finitude (8), and for nursing they expose care as the way in which persons come to matter (14). The meanings that emerged are best read as a single movement, not as separate domains.

The movement begins in exposure. Nurses described the boundary between themselves and their patients dissolving once danger was shared. This fits contexts in which patients, nurses, and nurses' families are exposed to the same threat (7). Palestinian nurses in the West Bank and Gaza, survivors of the same systemic violence affecting their patients, described a similar collapse of professional distance through shared trauma (15). That study concluded that its findings challenge Western models of detachment (15), and our participants' accounts point the same way. When nurse and patient stand under the same threat, distance becomes less a coping strategy than an unavailable option. The two contexts differ, since protracted structural violence is not sudden bombardment, but the shared structure of exposure is recognizable in both. In Heideggerian terms, the nurse is not a detached helper but co-exposed with the patient, in a radicalized form of *Mitsein* (8). Detachment is then best understood as a deficient mode of being-with, not a neutral professional stance. This shared exposure is also what makes staying, discussed next, thinkable.

From this shared fate, staying followed almost naturally. Because the nurse's own being was entangled with the patient's, leaving would have meant leaving a part of oneself, and participants described staying as a resolute act rather than obedience. Patriotism, faith and professional perseverance have been reported in comparable settings in Lebanon and Cameroon (16, 17), though usually as duty or commitment. Our participants added that their resolve was formed in full awareness of death. Structural constraint qualifies this: Iranian emergency nurses in 2025 noted that leave was cancelled because of

staffing shortages (7). Resoluteness in Heidegger's sense means owning a situation one did not choose (8), so "free choice" here is the participants' interpretation of a constrained reality.

What made this resolve bearable was meaning. Nurses interpreted care as worship and closeness to God, in line with Iranian critical care nurses in Syria, who described their service as "nursing jihad" alongside persistent mental preoccupations (18), and with Iranian ICU nurses for whom spirituality became a source of meaning and closeness to God (19). Yet faith should not be read as a complete shield. Iranian emergency nurses reported that spiritual resources sustained motivation without removing fear or distress (7), and a Gadamerian inquiry in occupied Palestine showed that cultural beliefs can interact with structural violence to produce layered moral distress (20). Meaning and suffering coexisted.

That coexistence was sharpest where demands converged. Concern for the patient, the family and one's own life arrived at once, without order. Palestinian nurses describe the same doubling, being providers and survivors of the violence affecting their patients at once (15), and Iranian emergency nurses reported persistent worry about relatives while treating casualties (7). Heidegger's thrownness (8) explains why prioritization collapsed: nurses were cast into a situation they had not chosen and could not put in sequence. Under this convergence, loss accumulated. Reviews and studies of health workers in disasters and war document a substantial psychological burden (21). In Beirut, 18.4% of surveyed healthcare workers were at high risk of post-traumatic stress symptoms, and higher scores were associated with the nursing profession and with direct war exposures such as displacement, personal injury, or the loss of a relative (22). Our participants add that trauma was heightened by witnessing others' grief and by the absence of time to mourn, a burden that resonates with Palestinian nurses' accounts of the psychological and political weight of bearing witness (20). Coping does not reliably buffer this burden. Among nurses in the southern West Bank, stress was significantly associated with reduced well-being, and coping strategies showed only limited mediating effects (23). This echoes our participants' description of moments in which no strategy was available. Other evidence points the other way: military nurses' accounts include growth through devotion to duty, and post-traumatic growth has been reported among Iranian nurses who served in war zones (18). Read through Angst, distress is not merely pathology but something that discloses what matters, which allows distress and growth to coexist.

This coexistence peaked where cure was no longer possible. Nurses redefined their purpose as presence, ensuring that no one died alone, and experienced this as the fullest expression of their professional identity. In peacetime ICUs, a dignified death is built from concrete practices such as privacy, family farewells, and fulfilling last wishes (24). Under bombardment, most of these were unavailable, and presence alone remained. Palestinian nurses caring for the dying under occupation describe this terrain as one of layered moral distress (20). Our participants experienced the same acts as fulfilment. Presence at the moment of death was, at once, the deepest wound and the deepest redemption, and this is where the two poles of the theme met.

The contribution of this study is therefore ontological. Existing evidence tends to organize wartime nursing into challenges on one side and coping or meaning on the other (25). Our interpretation suggests that these are not separable in lived experience, and that understanding nurses under bombardment requires holding both together. Practically, this means that support should not aim only at reducing symptoms. It should protect time to process loss, prepare nurses for presence-based end-of-life care when usual dignity practices are impossible, offer culturally grounded spiritual support without assuming it protects everyone, and avoid organizational measures, such as cancelled leave, that turn commitment into compulsion.

Strengths and limitations

The study offers interpretive depth and explicit philosophical grounding. Its limitations are a small sample from one cultural context, retrospective accounts, and interpretations that inevitably reflect the researchers' pre-understanding. Findings are transferable by resonance, not generalizable.

Conclusion

This Heideggerian hermeneutic phenomenological study shows that nurses who cared under bombardment lived at the edge of nothingness, where existential collapse and existential deliverance were experienced together, not in sequence. Shared fate with patients, a resolute choice to stay, and religious and spiritual meaning-making sustained their care, while colliding roles and repeated, unprocessed loss threatened to overwhelm them. When cure was impossible, they redefined nursing as dignified presence with the dying. Practically, support should go beyond symptom reduction. It should protect time to process loss, prepare nurses for presence-based end-of-life care in crises, offer culturally grounded spiritual and peer support, and avoid measures such as cancelled leave that turn commitment into compulsion. Future research should test these findings across other conflict settings and follow nurses over time.

Declarations

Abbreviations

No Abbreviation

Ethics approval and consent to participate

This study was conducted in accordance with the principles of the Declaration of Helsinki and was ethically approved by the Ethics Committee of Baqiyatallah University of Medical Sciences (reference: IR.BMSU.REC.1405.049). Participants provided informed consent and were assured of confidentiality and anonymity. Identifiable information was removed from transcripts. Participation was voluntary, and participants could withdraw at any stage.

Consent for publication

Not applicable.

Competing Interests

The authors declare no competing interests.

Funding

There is no funding available for this study.

Author Contribution

MR conceptualized and designed the study, supervised the research process, conducted data analysis, and drafted the initial manuscript. MP and F.D contributed to study design, participant recruitment, and data collection. S.H-O provided methodological guidance and contributed to data analysis and interpretation. Z.M and M.R assisted in data coding, validation of categories, and critical revision of the manuscript. MR and S.H-O contributed to the literature review, interpretation of findings, and manuscript editing. All authors participated in revising the manuscript critically for important intellectual content and approved the final version for publication.

Acknowledgement

The researchers would like to express their gratitude to the participants of this study. We also thank and appreciate the Vice Chancellor for Research of the Baqiyatallah University of Medical Sciences and Baqiyatallah Hospital.

Availability of data and materials

The interview guide used in this study is provided as Supplementary File 1 (English version). Anonymised illustrative quotations supporting the findings are included within the manuscript. The full interview transcripts are in Persian and contain sensitive first-person accounts of wartime experiences; to protect participants' confidentiality and anonymity, as assured during the informed consent process, they are not publicly available. De-identified excerpts of the transcripts are available from the corresponding author (Milad Rezaiye, miladrezaiye73m@gmail.com) on reasonable request, subject to approval by the Ethics Committee of Baqiyatallah University of Medical Sciences.

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