**Nursing roles in a disaster zone: Experiences and lessons learned from Turkey's earthquake events**

Keywords: disaster, emergency nursing, humanitarian aid, collaboration, fieldwork, critical care nursing, multicultural team

**Abstract**

**Background**

Disasters, both natural and man-made, are a global concern and significantly influence human health and welfare. Nursing provides an essential contribution to efficient organization, both before and during disaster events, as well as effective field treatment in the disaster zone.

**Aim**

The study explores the experiences of the Israeli humanitarian delegation dispatched to the Turkey earthquake zone during February 2023, including the preparation phase in Israel, the delegation’s activities at the disaster site, and conclusions drawn at the end of the mission. Of particular note was the fact that, unlike in previous humanitarian aid missions, the delegation had to integrate into functioning local healthcare systems and their protocols.

**Methods**

Following approval from the ethics committee, 22 nurses who participated in the humanitarian delegation were interviewed in three focus group meetings, after signing a consent form. The interviews were recorded and transcribed verbatim. The text was analyzed using a content analysis approach. 32 COREQ items were used as criteria for qualitative analysis.

**Findings**

The study revealed three main themes and 12 subthemes:

* Pre-departure preparation
* Work in the disaster site
* Post-delegation conclusions

**Conclusion**

Of the many essential functions that nurses serve in a disaster zone, we found particularly noteworthy nurses’ vital contribution to facilitating integration with existing local healthcare systems. Nurses actively pursued a respectful and sensitive approach and recognized the impact on the quality of care in a multicultural setting.

**Implications for Nursing and Health Policy**

Nurse managers and health policy stakeholders should utilize the study insights for future team-planning training programs and for fostering collaboration between international healthcare teams.

**Introduction**

In the recent decade, the global world has experienced an increase in the incidence of both natural and man-made disasters. An early response is necessary for effective humanitarian aid and saving lives (Li et al., 2023). During February 2023, two earthquakes struck the Kahramanmaraş region of southeastern Turkey within nine hours of each other, with magnitudes of 7.8 and 7.6, respectively. An estimated 57,000 people died in the most fatal event in the history of modern Turkey (Hussain et al., 2023).

Nurses play a central role in field hospitals in emergency settings (Pourvakhshoori et al., 2017; Segev, 2023). They are essential to hospital operations both clinically and psychologically: they coordinate care and provide on-the-ground solutions for the many problems and challenges that arise, maintain safety and constant communication in disaster areas (Richards et al., 2023), and preserve ethical standards for disaster victims (Moradi et al., 2020). Although nursing already fills these roles in emergency zones, there are still gaps in nursing education around preparedness training. Overall, there is a lack of disaster preparedness competence (Labrague et al., 2018; Taskiran & Baykal, 2019), poor disaster education and research (Al Harthi et al., 2020), and little prevention of long-term negative impact on nurses’ emotional state (Johal & Mounsey, 2017; Mounsey et al., 2016; Segev, 2023).

The Israel Defense Forces Medical Corps (IDF-MC) has had rich experience deploying humanitarian delegations and erecting field hospitals in disaster arenas since the 1953 Greece earthquake (Alpert et al., 2018). Between 2010 and 2016, IDF-MC operated six humanitarian hospitals worldwide (Glick et al., 2016). The IDF-MC delegation was deployed to Turkey on February 8th, 2023, 24 hours after the earthquake. The delegation included 58 physicians, 32 nurses, five paramedics, 15 laboratories, imaging personnel, and 23 administrative staff. They were all brought to an existing hospital building near the disaster area, in collaboration with local medical staff (*The IDF “Olive Branches” Humanitarian Delegation*, 2023). Many factors contribute to the successful operation of a foreign field hospital, such as effective logistical planning, appropriate equipment, respecting the demands of a foreign environment, and bridging cultural gaps and language barriers (Alpert et al., 2018). Collaboration with local and international teams has been described as essential in enhancing the quality of medical care (Bar-On et al., 2013). Foreign medical delegations usually establish their field hospitals independently and do not use local medical equipment and infrastructures (Naor & Bernardes, 2016). In contrast, the delegation in Turkey integrated into an existing medical facility.

The current study describes and analyzes the challenges and insights of the IDF-MC nursing delegation members in this unique situation.

**Aim of Study**

The study aims to explore nurses' experiences as part of a humanitarian aid delegation to Turkey following the 2023 earthquakes and to derive applicable lessons from those experiences.

**Methods**

Research Design

We used focus groups as the qualitative methodology, which help explore complex phenomena (Hamilton & Finley, 2019). For over sixty years, this methodology has been shown to elicit richer descriptions of experiences through group conversations (Sim & Waterfield, 2019). The authors were guided by COREQ 32 reported checklist (Tong et al., 2007).

Participants and Settings

Initially, we mapped out all the nurses who participated in the humanitarian delegation and contacted them by phone. Of 32 nurses, 22 agreed to participate in one of the three focus groups. The Zoom meeting format was chosen to enable participants from around the country to join at a time of their choice. Ten male and 12 female nurses with backgrounds in critical care or midwifery were interviewed (Table 1).

Data Collection

Three focus groups were conducted between March 2023 and May 2023. Participants joined Zoom meetings for 60-90 minutes. Two authors with qualitative interview experience guided the focus groups: one opened the conversation by presenting the researchers and the study aim, and the other guided the flow of the conversation. An interview guide with leading questions was prepared prior to the focus group meetings, containing questions such as: "What nursing preparations were made prior to departure from Israel?", "Describe your role in the delegation team", "What challenges did you face?”, and "How did you deal with those challenges?". All focus group conversations were video-audio recorded and were later transcribed verbatim.

Data Analysis

The transcripts were professionally translated from Hebrew to English and back-translated from English to Hebrew. All the transcripts were read and re-read by the researchers. The repetition of text was coded and categorized. Main themes and subthemes were extracted from the text.

Ethical Considerations

All participants received written information about the aim of the study. They signed a consent form for their participation in the study and for their responses to be recorded. Standard de-identification techniques were used. Participants had the freedom to answer or refuse to answer the questions. Access to the content was limited to the primary researchers. The study was approved by the IDF-MC review board (No. 0902-2023) and the XXX-XXXX University Ethics Committee (No. 0006518-2).

Rigor and Trustworthiness

The researchers measured the rigor and trustworthiness of the study data according to four criteria: credibility, transferability, dependability, and confirmability (Krefting, 1991). The primary investigators, who all held expertise in qualitative methodology, each analyzed the data separately and later compared and discussed their findings. Finally, participants were given the opportunity to read the findings and confirm their accuracy.

**Findings**

The research findings offer insight into the process of integrating local and foreign teams across multiple barriers: diplomatic and political tensions between Israel and Turkey, different languages, and cultural and social gaps. Interviewees described an initial sense of distance or “otherness” but noted that over time the interactions while providing care were characterized by a greater sense of closeness.

The study's main findings are presented along the axis of occurrence across a continuum of distancing/closeness, as experienced and described by the interviewees, in each of the three main themes identified in the study (Table 2):

* Pre-departure preparation
* Work in the disaster site
* Post-delegation conclusions

**Theme 1: Pre-departure preparation**

The nurses identified the recruiting phase in preparation for the mission as characterized by a positive sense of national mission, logistical issues, and flattening hierarchy between delegation members.

Subtheme 1: A sense of national mission

The staff responded positively to the invitation to join the mission. In the initial conversation, participants were given destination details and schedules. The sense of mission and partnership in a national mission outweighed doubts, as described by several participants:

"I'm looking forward to it” (Participant #2). “For me, it was a great excitement" (Participant # 7). “I immediately jumped at the opportunity; …Curiosity and pride overcame all fears”(Participant # 12). ”I chose to join really from a sense of mission. I think you don't overthink the details of what needs to be done, and if you believe in the mission....you just go. No matter what might happen to me, immediately, first of all, I said yes. …It was both an honor and a great privilege for me to participate in such a delegation" (Participant # 20).

Participant # 3 noted that it her present family situation was not a factor for her, as she described:

"I didn't think twice – the last time [I participated in such a delegation] I left a 5-month-old baby, and I didn't think this time either. When they asked me, I immediately said yes. First of all, this comes from a sense of mission; second, from a place where it seems clear to me that you are called to the flag."

Similar enthusiasm and sense of mission was expressed by interviewees who had participated in such delegations in the past, as expressed by Participant #10:

"This is not my first mission; I work on medical flights. But as soon as there is a task – everything lights up. The strength, the heart, and the energies will all be on the alert. A state of uncertainty and mental flexibility. Uncertainty. But we prepare for all scenarios. Prepare the mind and the heart. For me there is such a *rush* that you want to arrive, want to be there already."

Subtheme 2: Logistics of the mission

Interviewees noted several logistical issues that arose during the preparation phase. One of the issues was the extended time period between the assembly of the team and the actual departure, as expressed by Participant #15: "We received the alert Monday morning and the final okay at at 9-10 PM, and you are on a ‘hold’ mode for so many hours. We arrived at 8 AM – we were told our estimated departure time [to the disaster zone] would be that evening, but it was postponed and postponed and postponed and the 24-hour wait left an impression of disorganization."

Participant #16 adds: "There were many hours of waiting outside and inside the plane. From the moment we assembled, it took 36 hours until we landed in Turkey."

Uncertainty is very common during emergencies; many things are hard to anticipate in advance. One such difficulty is estimating the quantity and range of equipment required:

"There was a lack of wound-dressing equipment. The equipment that was packed was based on medical and surgical departments’ needs [such as] for the treatment of pressure sores or contaminated wounds, which you don't see in the field." (Participant # 9) "In terms of pediatric equipment, there were many improvisations and many things that we had no way to deal with and were simply spur-of-the-moment improvisations. It's worth maybe adding more pediatrics staff or pediatric care providers that will take care of children” (Participant #12).

Subtheme 3: Flattening hierarchy

One interesting observation mentioned by all the interviewees was that the professional hierarchy between delegation members faded into the background. Everyone collaborated to accomplish what was required in the organizational phase:

"Before we set up the emergency room in the disaster zone, I had not worked as an emergency room nurse. I loaded boxes and cleaned containers, assembled air conditioners, built tents. [I was] the person in charge of water and electricity, everyone works with everyone (Participant # 13). There’s no such thing as Professor, and there is no such thing as Lt. Col.” (Participant # 9). “By the time we arrived at the disaster zone, I agree with my colleague, everyone was equal" (Participant # 14).

Two interviewees added that the collaborative work contributed to setting the tone for the entire mission:

" Everyone is equal and everyone does everything right from the beginning. It creates an atmosphere that the whole group is unified; it’s an important process" (Participant # 2). "A mission of destiny... and for me personally it led me to work with people in a better way and connect to them, and the work really flowed better and I felt that everyone was pitching in and helping wherever possible in the following days" (Participant # 5).

**Theme 2: Work at the disaster site**

Several aspects of work in the disaster zone were challenging: weather conditions, working with local teams, language barriers, and different standards of care.

Subtheme 1: Weather difficulties

Entering the disaster zone was challenging first and foremost because of the weather conditions, as described by Participants #18 and #1:

"The day we departed, it was super rainy. All the equipment stood outside in the rain until it was put on the trucks... In Turkey it was also put on trucks where it was raining and cold... The tents were not prepared to receive staff members and there was not enough heating equipment."

Subtheme 2: Language barrier

Another difficulty that the humanitarian team faced was the language barrier. The local people spoke only Turkish and did not speak English. Several of the Israeli team could converse in Arabic, which enabled them to communicate with staff and patients, particularly the many refugees from Syria who were impacted by the earthquake. Participant #22 shares her perspective:

"I think that we [nurses] naturally have better communication skills than other professions. Improvisation, body gestures, express everything with emotion and don’t just be cold and technical. Both me and others noticed that it was easier for us to communicate with the Syrian patients in Arabic. We as caregivers have taken care of Arabic-speaking patients in our professional careers and have a certain level of medically oriented Arabic."

Participant #18 spoke Persian and therefore could be of help interpreting. However, she noted that effective translation services were provided by Turkish Airlines, Turkey's national airline, which came forward to help:

"Turkish Airlines staff who spoke English helped us amazingly. They didn't just help with translation; they wanted to help beyond that. At the level of reassuring families, reassuring patients, lending a hand, giving us water, buying us milk for coffee... It shouldn’t be taken for granted that [airline employees] would return from a flight and come straight to a hospital to help translate and be there for hours until their next scheduled flight. It was an excellent initiative and it really helped. I also think that we learned to communicate with each other."

Subtheme 3: Different standards of care

A significant challenge in Turkey lay in the Israeli delegation's operation within existing healthcare facilities, in addition to the diplomatic tensions between countries. Descriptions of tensions between local staff and delegation members recur in many of the transcripts:

"We entered a place, with a certain institutional behavior, with a certain way of working. For example, there were differences between us in handling sterile equipment and in how to take history and do a physical exam" (Participant # 15).

Subtheme 4: Communication between care teams

While the mutual desire to provide quality care built closeness among caregivers, the language barrier created distance. The shared medical knowledge offered common ground, but cultural gaps and different treatment approaches created a divide. The nursing staff described it as follows:

"The Israeli team would follow a ‘grand rounds’ routine to examine the patients. The Turkish team did not participate. The Turkish team made a separate round after that and then somehow [the two teams] would try to have a discussion. In the first few days, there was no discussion at all" (Participant #16). "But when you started working and they saw how we insert a catheter into a peripheral vein and how we dress a wound, they quickly accepted us. The language of professionalism breaks barriers. Shortly after they sat with us, showing us family pictures on their phones and drinking coffee together" (Participant #4).

Subtheme 5: Standard of care

Initially, there was suspicion and disagreement between the Israeli and local teams regarding medical approaches. As time passed, the Israeli nursing team learned to integrate into the local team and cooperate towards their common goal:

"A wounded patient would arrive and [local teams] weren't sure about him – they called us, asked us to come and help" (Participant # 6). "I think that after we received the first patient and they saw how we treated him, there was an increase in trust, and you could see it because when there were more difficult cases, a resuscitation or a child who was brought to us on the verge of death, they took a step back. The local doctor in charge cried and asked us not to go [back home] because they understood that we were doing good, doing it with respect, while having a dialogue with them and having good intentions" (Participant #22).

**Theme 3: Post-delegation conclusions**

The delegation’s departure from the Turkish hospital and the process of transferring information and tools to the local teams went relatively smoothly. Besides the lessons learned from formal debriefings, several issues emerged from the focus groups that perhaps should be considered by future delegations, such as. ensuring an optimal ratio of nurses to doctors, better use of the time prior to the delegation’s departure from Israel, and language compatibility of electronic medical software.

Subtheme 1: Nurse/doctor ratio

There were not enough nurses relative to the number of doctors, as reflected in Participant #16’s comments:

"The main perceived disadvantage...the numerical ratio between nurses and doctors in the workforce was not so balanced. I think there were more than enough doctors and too few nurses."

Subtheme 2: Better use of the pre-departure time

The time leading up to the delegation’s departure from Israel could have been used more effectively, for team members to get better acquainted with one another and for better briefing and preparation:

"We need to use this day [the day of getting ready for departure] in a more effective way, even if it only means getting to know who I work with because I did all this myself, I started talking to people about who you are and what you are... If you board the plane and already know who you will be working with you’re at a much better starting point" (Participant # 8).

Additionally, the delegation's nurses were tasked with vaccinating the team ahead of departure. Several interviewees suggested that such logistical tasks be assigned to caregivers from outside of the delegation.

"The deployed nurses vaccinated everyone in the delegation...I do think that an external person could have vaccinated and made some kind of order, because there were those who wanted to work. I believe that everyone wanted to work, but there were those who had more and those who had less desire and it could have been much more effective" (Participants # 9,# 2,# 13).

Subtheme 3: Medical reporting software

The electronic medical record software was new and unfamiliar to some of the delegation participants. In addition, the user interface in Hebrew made it difficult for local staff to use.

" I had never seen our documentation system before, and I would have been happy to study it a little before" (Participant #5). "The Israeli computerized system... is irrelevant because it is in Hebrew and is not translated to Turkish. The [patient] documentation that was passed on to the Turkish team was all in Hebrew, and they would write notes and try to understand what we wrote" (Participant #1).

Subtheme 4: Processing the experience

In the focus groups, the nurses noted that they were contacted by military psychologists after their return to Israel. However, there was a prevalent feeling that there was insufficient group closure following the traumatic experience they underwent, despite personal conversations and honorary events. Participant # 9 explained:

"In my view, there was no closure , and it was missing. Everyone can talk about it on their own, but no one gathered the group [to talk]. Three days ago, I had dreams about Turkey again. I don't know where they came from... There was a very nice closing event initiated by the medical corps that held an appreciation evening, but there was no room for talking."

**Discussion**

Three major themes emerged in this study, corresponding to three time phases: pre-departure, work at the disaster site, and post-delegation conclusions. *Pre-departure preparation* was the first theme identified by interviewers. Nurses felt a sense of mission participating in the humanitarian aid delegation, highlighted logistics issues, and described equal teamwork between delegation members. International studies have examined nurses' experience during the preparation phase before deployment, and noted the positive emotions associated with a sense of mission on the one hand (Christensen & Wagner, 2022; Moradi et al., 2020), and dealing with logistical concerns on the other hand (Al Harthi et al., 2020; Alpert et al., 2018; Richards et al., 2023). Flattening the hierarchy among delegation members contributed to the team’s sense of unity, however we did not find prior mention of this in the literature.

*Work at the disaster site* was the second theme that emerged*.* Nurses noted environmental difficulties like the weather, but primarily focused on the interaction with locals, particularly the local medical teams. They identified cultural differences and divergent perspectives, which formed formidable barriers, but also recognized in them a chance for potential collaboration. Consistent with the current study, the literature has identified extreme weather conditions as a staff challenge (Hamdanieh et al., 2023). Due to massive infrastructure damage in disaster zones, foreign delegations may only rarely find local buildings or equipment available for use (Naor & Bernardes, 2016). Working with a local medical team in an existing hospital, as in this study. is considered unique. Differences in cultural and professional perspectives amongst international groups of nurses have been recognized for many years (Purnell, 1991). Although studies highly recommended improving cultural knowledge, and thus improving collaboration with local medical teams (Bar-On et al., 2013; Chin et al., 2022; Lind et al., 2012), to date we have found no cases of real-time collaboration between foreign and local teams at a single disaster site.

*Post-delegation conclusions* was the third major theme that emerged from the focus groups. The nurses shared insights learned from serving at the disaster zone. In interviews, the recommendation to increase the nurse/doctor ratio emerged. In contrast, a previous study had pointed to the need for more expert physicians in field hospitals (Burnweit & Stylianos, 2011). Better use of pre-departure time and internationalization of electronic medical record software were also identified as areas which could be improved for future delegations. While several studies have revealed an insufficient level of preparedness among nurses for disaster response and management (Al Harthi et al., 2020; Taskiran & Baykal, 2019), this study offers new insights from nurses themselves on overcoming these challenges by more efficiently utilizing pre-deployment time, educating delegation teams on the disaster zone, and actively encouraging team cohesiveness. The nurses’ need to process the experience upon their return from the mission was the last revealed insight. Although many studies have emphasized the importance of providing psychological support to teams providing disaster relief (Johal & Mounsey, 2017; Mounsey et al., 2016; Sadhaan et al., 2022; Segev, 2023; Xue et al., 2020; Zahos et al., 2022), and despite the fact that delegation members were offered some degree of psychological support upon their return, the current study indicates that further improvement would be welcome.

**Study limitations and future directions**

One limitation of the study may be that it relied solely on nurses' perspectives. Interviewees from other professions or logistical disciplines, as well as drawing on both foreign and local perspectives, would have offered a broader perspective on the topic. We recommend interviewing participants from a range of disciplines to shed light on multidisciplinary team work on local and international levels.

**Conclusion**

This study emphasizes the crucial role of nursing in emergency disaster relief. Nurses may contribute to designing effective preparedness measures owing to their own multifaceted experience and skills. They act as moderators between local and foreign teams and as cohesive factors in multidisciplinary delegations. The study contributes to evidence-based knowledge on emergency response and adds a new perspective on disaster nursing benefits that may be utilized to improve future disaster interventions.

**Implications for nursing and health policy**

Nursing managers and educators may use the study's insights to improve disaster and emergency nursing competence and enhance care capabilities. Recommendations that emerged from nurses' experiences could improve future planning of disaster relief programs, from pre-deployment phase to the conclusion of the mission. Healthcare stakeholders may benefit from the unique insights revealed here addressing multicultural team collaboration in emergency states, and planning international emergency-response collaboration training for local-foreign partnerships.

**Author Contributions**

Study design: RS, LZ, AS; data collection: RS, MS, RG, AS; data analysis: RS, AS; manuscript writing: RS, MS, AS; critical reading and revisions: RS, MS, RG, LZ, AS. Study supervision: RS, AS.

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