**Abstract**

Background: The nursing profession’s development has been intimately connected with war. Formally recognized since the mid-1800s, nurses have helped manage wounded care in battlefield field hospitals, improving the outcomes for injured soldiers and often incurring physical and emotional injury themselves. Today, nurses are increasingly being deployed to provide care in crises that share important characteristics with battlefield nursing. While much is known about clinical military medicine, less is known about the experiences of nurses who provide crisis care during war. This qualitative study explores this question through interviews with nurses who originally trained to work in hospital emergency departments, intensive care units, and operating theaters and were then redeployed to serve during major emergency wars in Israel between 1967 and 1982. Despite differences in time and context, these nurses describe common experiences, including their crucial roles in field hospital functioning and management, their numerous logistical and psychological challenges, and their similar coping strategies Importantly, their wartime experiences continue to influence them to this day.

Methods: Qualitative, semi-structured, in-depth interviews were conducted with twenty-two former military reserve nurses who served in field hospitals in one or more major wars between 1967 and 1982. Transcripts from the interviews were analyzed using a content analysis approach. The Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist, guided the selection of methods, analysis of data and presentation of findings.

Findings: The data analysis revealed three themes and ten subthemes in nurses’ recollections of their wartime experiences. Major themes included Field Service Challenges, Ways of Coping with Field Service Challenges, and Nurses' Self-Recognition of their own Contributions.

Conclusion: Since at least the late 1800s, nurses have provided pivotal support during wartime. They are also increasingly being asked to apply skills typically exercised during wars to respond to natural or man-made disasters. The current study identifies mental, emotional, and organizational issues resulting from nurses’ experiences during wartime. The study emphasizes the importance of pre-deployment preparation, the need for emotional support during and after wartime service, and the significance of acknowledging nurses’ professional contributions to field hospital's organization and its mission of saving life.

Clinical Relevance: Nursing during wartime is a unique but, unfortunately, not a rare clinical situation. Nurses return from their wartime experiences with invaluable knowledge that can be significant for nursing and health policy stakeholders planning the field hospitals of the future for war or other disasters. Policies are needed to prepare nurses for such experiences prior to deployment, support them during these experiences, and enable them to process these experiences emotionally at their conclusion.

Implications for Clinical Practice

\* Preparing nurses for serving in a crisis zone is essential for their readiness and affects their short- and long-terms practices.

\* Nurturing supportive emotional relationships among nursing, medical and paramedical staff during and after crisis deployment is critical for decreasing negative coping strategies, stress and trauma.

\* Official and public recognition of the value of nurses’ efforts to save lives and comfort soldiers during and after working in a crisis zone is very meaningful to nurses and may empower them and enhance their self-esteem.

**Key Words:** emergency nursing, field hospital, military nursing, history of nursing, Israeli Defense Forces, nursing care, wartime nursing

**Introduction**

The nineteenth century was a decisive period in the development of military nursing. Florence Nightingale’s knowledge of the importance of sanitary conditions and a proper diet for the healing process resulted in a significant reduction in the number of fatalities amongst British soldiers wounded during the Crimean War (1854–1856). Nurses serving during the American Civil War (1861–1865) also began seeking more medical authority, convinced that they could more successfully care for wounded patients if environmental conditions received more attention (Keeling, MacAllister and Wall, 2015; Vuic, 2013).

These nurses’ achievements resulted in a paradigm shift about the conditions deemed necessary to help soldiers recover from battlefield injuries. This change in approach was supported by numerous improvements and advances, often discovered by nurses during twentieth century wars. These advances led to declines in infectious diseases and the development of pioneering medical treatments for war injuries. Thus, in Western countries, military nursing and medical technology progressed reciprocally, becoming interdependent, while remaining separate from the civilian medical system (Agazio, 2010; Hallett, 2009; Segev, 2020).

In contrast, in Israel, military and civilian medical services are tightly entwined (Segev, 2020). Conscription into military service, and the proximity of the wars to the home front fought by the Israeli Defense Forces (IDF) create conditions closely linking the civilian and military spheres of medicine, as seen in the cooperation between Israeli civilian hospitals and the IDF medical corps during armed national conflicts (Segev, 2020). Wartime service for nurses demands versatility, mediation, and the ability to cope with an ever-changing and dynamic environment (Brooks and Hallett, 2015; Dolev, 2020; Hallett, 2009; Segev, 2020).

Nursing has been defined as inhabiting “the borderlands between the delivery of scientific solutions and the creation of conditions in patients and their environments that will permit healing”(Brooks and Hallett, 2015)*.* This broadly describes the nurse’s role as a mediator in the healing process, and suggests a division of nurses’ duties based on science and intuition (Hallett, 2009). The scientifically based aspects of the nurses’ role, related to proven treatments to facilitate the healing process among wounded patients, have been described in great detail (Keeling et al., 2015; Martin and Weir, 2020). The second and highly debated aspect of nursing beyond mediating in the care process — nurses’ duties — is more difficult to define. Some assume that nurses define their own duties whilst considering such factors as personal motivation, a subjective value system, and the probability of receiving recognition for potentially life-threatening work carried out in severe environments (Agazio, 2010; Brooks and Hallett, 2015; Hallett, 2009; Keeling et al., 2015; Vuic, 2013).

The field hospital is the military nurses’ working environment; it was here that in the last almost two hundred years nursing became a well-established medical profession. The field hospital is designed to provide medical treatment during disastrous events —occurrences disrupting normal life and resulting in a high demand for medical services unmeetable by the affected community. Traditionally, field hospitals have operated as mobile units linking the battlefield and permanent hospitals. In the modern era, while military nurses work during armed national conflicts, they also play an important but commonly overlooked role in humanitarian relief missions to regions around the world struck by natural or others disasters (Adler, 1989; Dolev, 2020; Keeling et al., 2015; Martin and Weir, 2020).

Post-disaster environments, whether from natural or man-made disasters, are unstable and potentially dangerous. Studies have found that military nurses in these environments experience a blurring of roles, arising from a combination of their lack of mission-specific training, the scarcity of medical provisions, and the complex injuries and medical crises diagnoses they must make. These conditions result in an extension of the nurses’ duties beyond their official qualifications, and military nurses have so described their experiences of taking leadership and teaching roles within field hospitals (Adler, 1989; Agazio, 2010; Brooks and Hallett, 2015; Goodman, Edge, Agazio and Prue-Owens, 2013; Keeling et al., 2015; Lal and Spence, 2016; Lj, Standard, Kenward and Kenward, 2015; Zinsli and Smythe, 2009).

This expanded authority has been found to create professional dilemmas that may cause long-lasting mental health issues (Elliott, 2015). A possible explanation is that the undefined nature of the military nurses’ job and the unstable settings in which they operate act as stressors, especially when combined with a low level of mission-specific preparedness (Agazio, 2010; Hallett, 2009; Lal and Spence, 2016). The moral distress they experience is often perceived as resulting from their inability to perform to their own personal and professional standards (Baack and Alfred, 2013; Fry, Harvey, Hurley and Foley, 2002). This phenomena is also common in intensive care setting and without an intervention could negatively affect the nurses and may couse to burnout, job dissatisfaction and poor quality care of patients (Forozeiya et al., 2019; Imbulana et al., 2021).Phenomenological studies have found that previous deployment experience, communication skills, and a sense of belonging and unity among the medical staff serve as coping mechanisms for military nurses facing such difficulties (Almonte, 2009; Gholami, Sarhangi, Nouri and Javadi, 2015; Goodman et al., 2013; Lj et al., 2015; Noguchi, Inoue, Shimanoe, Shibayama and Shinchi, 2016; Ormsby and Harrington, 2003).

**Background**

After Israel’s establishment in 1948, the government focused on building a healthcare system for its population, which was growing rapidly due to massive Jewish migration to Israel from around the globe. To meet the demands for nurses and medical centers, military hospitals were shifted to the Ministry of Health’s authority. Since then, most drafted nurses complete their military service in civilian hospitals, and qualified nurses from civilian emergency departments, intensive care units, and operating rooms are recruited from civilian hospitals to war efforts and other disasters during emergencies (Segev, 2020).

The few previous studies on military nursing have been based exclusively on the experiences of Western (non-Israeli) military nurses participating in humanitarian or wartime missions (Brooks and Hallett, 2015; Keeling et al., 2015; Scannell-Desch and Doherty, 2010). Research into IDF field hospitals has focused mainly on humanitarian missions, describing their organizational structure and analyzing data on the type and severity of injuries and the number of patients treated by field hospital staff. From this analytical perspective, only a few researchers have discussed issues about the personal level of preparedness and safety, the professional dilemmas encountered, and the resulting implications for nurses’ mental and physical health (Amital, Alkan, Adler, Kriess and Levi, 2003; Bar-Dayan et al., 2000; Erlich et al., 2015; Kreiss et al., 2010; Lachish, Bar, Alalouf, Merin and Schwartz, 2017; Lichtenberger et al., 2010; Merin, Ash, Levy, Schwaber and Kreiss, 2010). The purpose of this study is to fill this void by presenting insights derived from the experiences of Israeli military nurses in field hospitals while serving during major armed national conflicts.

**Methods**

Design

In this study, a qualitative descriptive design was conducted, utilizing in-depth interviews. Data from the interviews were analyzed using content analysis in order to obtain a better understanding of the former IDF nurses’ experiences, their perspectives on serving in field hospitals during wartime, and the long-term impact of those experiences.

Participants

Twenty-two nurses, retired from the IDF military reserves, were interviewed for this study including three males and 19 females. Each had served as a nurse during one or more of the wars Israel fought between 1967–1982: the Six Day War of 1967, the October War of 1973 or the First Israel-Lebanon War of 1982. Participants were recruited via purposive sampling. Participants were recruited using a call on social media like history seeking's groups in Facebook and other websites to get to relevant audience and the IDF’s archive website, and after consultation with key members of the medicine corps. Additionally, some interviewees made suggestions to the researcher regarding colleagues with whom they had served and who could be potential interviewees.

All participants provided written consent prior to their interviews.

Ethical Considerations

The XXXX University Ethical Committee approved the research protocol. Participants were informed of their right to refuse to participate or to terminate their participation at any time. The study participants received written information about the research and its purpose and chose the place and date for their interviews.

Data Collection and Analysis

Face-to-face, in-depth, and semi-structured interviews were conducted between November 2011 and October 2017(data saturation received). Interviews lasted from 60 to 120 minutes on average. The interviews used open-ended questions that asked for background information, followed bytheir job prepration and training. Following this, interviewees were asked more focused open-ended questions, for example: In your opinion, did you experience any significant military event? What was it? What was the nurses’ role in this event? What was your military training for this event? To gain a deeper understanding, the researcher added purposeful follow-up questions based on participants’ answers.

All interviews were recorded and transcribed. The researcher then identified and extracted the meaning units that emerged from the transcriptions. Meaning units were labelled, consolidated, and coded. Codes were compared according to similarities and differences to formulate new categories. The categories were grouped, and this analysis process continued until the main categories and the connections between them emerged.

Rigor and Trustworthiness

To eliminate the possibility of researcher bias, data analysis results were shared with three qualitative research experts who read and approved the data description’s accuracy. In addition, transcripts were returned to interviewees to ensure the accuracy of the researcher’s recollection and interpretation. The researcher also used the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist for the methods, findings and analysis process (Tong, Sainsbury and Craig, 2007).

Findings

Three major themes and ten subthemes emerged from the interview transcriptions (Table 1). The three major themes include: (1) Field service challenges, (2) Coping strategies, and (3) the nurses self recognition and their needs for official recognition of their contributions to saving lives during war.

Theme One: Field Service Challenges

The findings show that nurses faced numerous challenges during their warzone service, which were divided into four subthemes described below.

Subtheme: War service without military experience

Many participants, especially those who usually worked in civilian emergency departments, intensive care units, and operating theaters were deployed to serve in warzones as part of the IDF reserve forces due to their special clinical experience. Many had not served in the army before, and of those who had, most had not served as army nurses. They were all, were jolted by their exposure to the army and to war, and their experiences had a profound impact on them. The nurses shared their experiences; for example: “We did not know what to expect in a war zone. We had no knowledge about either using our weapons or how to manage a field hospital. We did it in real-time, using our common sense, using our skills from civilian wards.”

Subtheme: Water supply and difficulties in hygiene maintenance

Female nurses described insufficiency of the water supply as a major difficulty. This problem affected their personal hygiene and their ability to provide safe and quality treatment for the wounded. Nurses’ comments included: “From the beginning of the war we had not taken a shower. We only washed our face, hands and genitals. We had to face an insufficient water supply. At one time we would have water, and later we wouldn’t. It was a serious problem to maintain the hygiene of our hands and the medical equipment. We used to drink sterile water from the operating room and we (female nurses) washed each other in a minimal way from a water bottle.”

Subtheme: Exposure to harsh scenes of war

Exposure to the horrific scenes of war was the most significant issue the nurses related. Consistent with findings from previous studies documenting Post Trauma Signs among battlefield nurses (Agazio, 2010; Kenward and Kenward, 2015 ), long after the experiences the interviewees described, these scenes loomed large in their stories. They may have put the experiences aside at the time, but the memories remained with them: “I remember the clotted blood with its uniquely acidic smell. Seriously wounded soldiers came to us with their chests and abdomens open. They showed up dirty with soil, blood, and even the food they had for lunch spread all over their open chests.” Another recalled: “The sight of the burned soldiers, the sounds of helicopters, and the pounding of nails to make coffins for dead, refuse to leave me until today.”

Theme Two: Ways of Coping with Field Service Challenges

Participants adopted various ways of coping with the challenges of service in a warzone. Four subcategories of coping mechanisms can be identified: improvisation; maintaining cohesive staff relationships; emotional/mental ventilation; and avoidance and denial.

Subtheme: Improvisation

Nurses used improvisation and creativity to overcome the medical demands placed on them during the wars. They had to find adequate ways to sterilize the surgical equipment in desert conditions and sandstorms and solutions for disposing of needles and biological waste. As one described: “We faced a lack of medical equipment, so we called our friends overseas and they sent us a lot of necessary items. If anyone from the hospital went home on leave, we asked them to bring back specific things.” One nurse described an unusual case when they needed an orthopedic nail for fixing an injured soldier’s elbow: “I sent a soldier outside the operating room to sterilize a non-medical nail, under fire. Unfortunately, the soldier whose elbow we fixed did not survive.”

Subtheme: Maintaining cohesive staff relationships

Participants described how nurses, physicians, and medics supported each other during the war as a coping strategy. The social environment was crucial in maintaining their ability to act efficiently. As one participant related: “We were working in harmony, with collaboration between us. We stayed in tents together — male and female. Our commanders ordered us to separate the tents by gender, but we refused to do so. In this way, we could overcome this difficult and stressful time.”

Subtheme: Emotional/Mental Ventilation

Nurses gave vent to their emotions through actions that enabled them to continue functioning. Crying or taking a shower between patients were popular coping mechanisms. As one participant recounted: “After each surgery I went to take a shower, pouring out my heart in tears, washing myself, changing to a clean uniform, then going back like a new person.” For another participant, “The meetings between several field hospital staff members to exchange equipment and blood products enabled us to ventilate and share the emotional burden. That helped us to move on with renewed energy.”

Subtheme: Avoidance and Denial

Participants revealed that one of the strategies that helped them function was denial, such as avoiding looking at the faces of the wounded or learning their names. One said: “After a resuscitation event, I went outside and did not want to meet anyone. We worked like robots and did not talk about the war. We were also avoided learning the soldiers’ names. We were afraid to encounter someone we knew.”

Theme Three: the nurses self recognition and their needs for official recognition of their contributions

Participants discussed their contributions to war efforts. Most of them recognized the sacrifices they made to help the wounded and to the military forces and hoped the country would recognize their contributions. Three main constructs emerged under this theme: organizational and management aspects; contributions to helping the wounded; and expectations of acknowledgment and recognition from the military and governmental authorities.

Subtheme: Organizational and management aspects

Nurses had to draw on organizational skills during their wartime service. They participated in building field hospitals, managed human services, allocated medical instruments, and took care of the welfare of all the field hospital staff. Nurses’ comments included: “We managed the human resources throughout the hospital. Our civilian experience enabled us to act by prioritizing according to the urgency of missions. We found ourselves taking intimate care of all the women in the military base zone. We also took care of the dignity and memory of those who died by collecting their personal belongings and later giving them to their families.” Another added: “We were always thinking about the hospital’s needs. We maintained the medical equipment and prevented waste of materials for dressing wounds. We worked after our shift ended and gave our turn to go for short vacation to those who had families and children.”

Subtheme: Contributions to the helping the wounded

Most of the participants acknowledged their contributions to helping injured soldiers. Many of them reported that the reactions from the wounded gave them energy and justified their service in a hostile warzone environment. One recounted: “Soldiers who felt the nurse’s hand or even her feminine voice gained strength and hope to fight for their lives. They told us this.”

Subtheme: Expectations from military and governmental authorities for acknowledgment and recognition

Most of the nurses expected acknowledgment and recognition from the medical corps and from governmental authorities, but this was unfulfilled. They believed the reason lay in the fact that nurses did not dedicate time to documenting their activities, since after the war they were busy with building families and raising their children. As one participant stated: “Some of us got a certificate of appreciation by mail. We did not get the deserved attention for our contribution. At that time, we did not think our story should be publicized, because we did not perceive it as a special act.”

Discussion

Our study adds to previous studies that have addressed nurses’ experiences in wars (Biedermann, Usher, Williams and Hayes, 2001; Farsi, 2017; Lj et al., 2015; Rahimaghaee, Hatamopour, Seylani and Delfan, 2016; Scannell-Desch and Doherty, 2010; Stanton, Dittmar, Jezewski and Dickerson, 1996). The themes emerging from this study reflect the nurses’ experiences during wartime, the findings showing that even many years after the events, the nurses remember them clearly enough to describe their challenging work in war field hospitals. The nurses developed multiple ways of coping with the demands of service in a warzone. From the interviewees’ point of view, the issue of the nurses’ contribution was predominant, and their need for recognition of their contributions were evident.

In several previous studies, as in the current study, nurses emphasized that they had not known what to expect in the war zone (Biedermann et al., 2001; Stanton et al., 1996). However, in contrast to participants in our study, the nurses surveyed in other studies had military backgrounds. Understanding nurses’ prior experiences can help better prepare the staff for future events (Farsi, 2017). A well-planned preparatory program before deployment could give the field hospital staff the skills necessary for providing healthcare in a stressful military environment (Sprinks J, 2013).

Our study is also consistent with previous research regarding the difficult living and working conditions during wartime service, such as difficulties in maintaining bodily hygiene and providing high-quality care (Scannell-Desch and Doherty, 2010). There is significant evidence supporting the subtheme of Exposure to Harsh War Scenes in the scientific literature. Many studies describe and address nurses’ harsh experiences, including exposure to the sights and smells of war causalities (Farsi, 2017; Hagerty, Williams, Bingham and Richard, 2011; Scannell-Desch and Doherty, 2010; Stanton et al., 1996).

One study found that military nurses learned to improvise so they could provide efficient care for the wounded because the warzone hospital arena is significantly different from the conditions in a civilian hospital (Stanton et al., 1996). This finding is consistent with the theme this study uncovered of Ways of Coping with War Services Challenges, and the subtheme Improvisation. Nurses must be creative in finding solutions to the problems that arise. Maintaining cohesive staff relationships, a subtheme of the current study, was also found in other studies to be a major factor in coping with the challenges of war (Farsi, 2017; Finnegan et al., 2016; Rahimaghaee et al., 2016; Stanton et al., 1996).

One coping strategy revealed in this study is that of crying, which appears as a prevalent way to release emotional and mental stress. Farsi’s study also found this to be a common strategy, especially among those facing wounded youth and patients with extensive injuries. Farsi concluded that the ability to express emotions in a stressful situation helps to reduce anxiety and enable better coping with the conditions (Farsi, 2017).

In the same context, avoidance and denial were also found to be coping strategies used to protect oneself from confronting painful information, such as names or personal details about the wounded. These negative strategies, when used in the immediate term, may prove helpful in avoiding the stressors, but in the long term, they could lead to depression and dysfunction for the caregiver staff (Farsi, 2017; Ribeiro, Pompeo, Pinto and De Cassia, 2015).

Our study’s third theme reveals the participants’ recognition of their own contribution. Israeli military nurses were found to demonstrate administrative skills in organizational and management contexts that enabled them to address administrative as well as clinical issues. We did not find this subtheme in other studies, although Scannell-Desch and Doherty (2010) noted that military nurses improved their clinical skills during the Iraq and Afghanistan wars. In our study, nurses came to the war situation with a high level of clinical skills gained from working in civilian wards, and then developed their management skills during their war service.

Our participants described their contribution to helping the wounded as one of their major achievements. This finding echoes another study in which the participants described the relationships they created with the wounded as having a positive effect during this stressful event (Stanton et al., 1996). One of the unique subthemes that emerged in this earlier study refers to the participants’ need for acknowledgement of their contributions from military and governmental authorities. As our study and others show, military nurses serve with remarkable commitment but while they do not see themselves as heroes (Sheehy, 2007), they still feel the need for recognition. This need for recognition may not have emerged in other studies since many countries honor and acknowledge their own country's military nurses for their contributions in war in publications and commemorations (Ashton, 2015; Gadd, 2015; “In Brief: Nurse killed in Iraq,” 2007; “News: New coin to honour army nurses,” 2017).

Conclusions

This study contributes to the literature describing the experience and impact of battlefield nursing. Using in-depth interviews with nurses who fought in three wars in which Israel was engaged between 1967 and 1982, nurses described common experiences, immediate and long-term challenges. Investigating this issue many years after their wartime experiences is one of the study’s limitations; some participants had difficulty overcoming the obstacles to memories presented by the passage of many years. On the other hand, conducting the study from this time distance not only provided a wide perspective on the subject across more than one war, it also confirmed the existence of long-term impacts from wartime experiences as well as common patterns in coping with them.Although between 39 and 54 years have passed since the end of these respective wars, participants still live with harsh and unprocessed war experiences. Among the most beneficial experiencethat nurses reported was the need for recognition by officials/society. Officials’ acknowledgment and recognition could help nurses feel more valued, and documenting their contribution as part of the professional and national heritage legacy could support and encourage those who served in the past, as well as those just entering the nursing profession.

Implications for Nursing and Health Policy

Nurses serving during crisis/ wartime face many challenges. Appropriate pre-deployment clinical and general preparation may reduce uncertainty and make mission/ military concepts more familiar to nurses, most of whom are deployed to war with little or no crisis/emergency/military background. Supplying advanced facilities and mental/emotional support during wartime service can help them process harsh experiences, strengthen positive coping strategies, and prevent long-term painful consequences.

At the end of a war, it is recommended to convene all the nurses, receive their feedback and insights, acknowledge them during a Nursing Week or on Memorial Day with ceremonies, and grant them certificates of appreciation. Documenting and publishing their stories in professional literature and public media can undoubtedly increase national and individual pride in nurses and the nursing profession.

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