The Impact of Health Crisis on Nurses' Lives: A Qualitative Exploration Using Van Manen's Lifeworld

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https://doi.org/10.61211/mjqr110206

ABSTRACT

Nurse wellbeing is essential for sustaining effective healthcare, especially during public health crises such as the COVID-19 pandemic. This qualitative study used interpretive phenomenology to explore nurses' lived experiences and perceptions of the pandemic's impact on their professional and personal lives. Ten nurses from Sarawak General Hospital participated in semi-structured interviews. Data were analysed using thematic analysis. From the findings, three key themes emerged: Adapting to Workplace Challenges, Strengthening Camaraderie in the Healthcare Environment, and Upholding Commitment and Professionalism. Nurses faced significant psychological strain due to role ambiguity and rapidly changing protocols, alongside physical exhaustion from extended shifts and personal protective equipment (PPE) demands. Collegial solidarity, family support, and empathetic leadership were crucial protective factors enhancing resilience. Intrinsic motivation grounded in cultural and spiritual values sustained nurses' dedication despite systemic challenges such as hierarchical discrimination and unequal workload distribution. The findings were interpreted through Van Manen's four lifeworld existentials: lived body, lived time, lived space, and lived other, providing a comprehensive understanding of the pandemic's complex impact on nurses' lived realities. In conclusion, the nurses in this study demonstrated resilience through adaptability, strong collegial bonds, and a profound sense of duty amid adversity. The study underscores the urgent need for organizational support via clear communication, flexible yet standardized protocols, ongoing training, equitable policies, and supportive leadership. Enhancing mental health resources and utilizing technology to maintain social connectivity are also essential. A holistic approach is critical to supporting nurses' multidimensional wellbeing, thereby ensuring workforce sustainability and healthcare system resilience during current and future health emergencies.

Keywords: Impact of health crisis, nurses' lives, Van Manen's lifeworld

Article Info:
Received: 26 June 2025
Accepted: 31 August 2025
Published: 30 November 2025

INTRODUCTION

The World Health Organization (WHO) defines well-being as a multidimensional state wherein individuals realize their potential, effectively manage life's stresses, work productively, and contribute meaningfully to their communities (Wistoft, 2021). This holistic view of wellbeing integrates emotional, cognitive, behavioural, and relational dimensions, illustrating the complex interplay of personal and social functioning (Aaron & Roache, 2023). For nurses, well-being encompasses maintaining mental health, feeling valued in their professional roles, and balancing demanding work responsibilities with personal life commitments. These crucial aspects of well-being are significantly shaped by individual life stages and cultural contexts, underscoring the need to understand nurses' diverse backgrounds and lived realities.

Nurses are central to healthcare delivery, making their well-being essential for maintaining high standards of patient care, particularly during health crises. The COVID-19 pandemic has exposed nurses worldwide to extraordinary professional pressures and emotional distress, underscoring the urgent need to investigate their experiences comprehensively. Human experiences are inherently dynamic, shaped by sensory perceptions, emotional responses, and cognitive interpretations that collectively influence personal narratives, memory

formation, identity, and behaviour (Galvano, 2015). Traumatic events, such as pandemics, intensify these processes, embedding lasting psychological and emotional impacts within nurses' lived experiences. Thus, nurses' well-being must be understood through a multidimensional lens, encompassing the physical, psychological, and social domains that are critical to holistic health.

In Malaysia, despite increased healthcare personnel, the nurse-to-patient ratio remained critically low at approximately 1:279 in 2024, significantly below international standards, contributing to fatigue, workplace errors, and dissatisfaction among nurses (Jayakumar, 2024). In Sarawak, a culturally diverse state with substantial indigenous populations, the COVID-19 pandemic posed unique challenges beginning with its initial outbreak in March 2020 (Sipalan, 2020). Sarawak General Hospital is a major tertiary care and primary COVID-19 referral centre in Sarawak, Malaysia. It provides a culturally diverse and high-demand clinical setting conducive to exploring nurses' experiences. The hospital, which has the primary referral facility, swiftly adapted by repurposing wards to manage rising patient volumes.

This qualitative study primarily seeks to explore Sarawak nurses' lived experiences and perceptions regarding the impact of the COVID-19 pandemic on their professional roles and personal lives. Given the complexity and contextual specificity of nurses' experiences, qualitative methods facilitate the capture of these nuanced perspectives directly from nurses themselves, providing essential insights into the human dimensions of healthcare crises (Moser & Korstjens, 2018). By illuminating these detailed narratives, this research aims to inform targeted policies and practical interventions to enhance nurses' well-being and bolster the healthcare system's preparedness for future public health emergencies. Thus, the research questions for this study are:

1. What challenges do nurses encounter during the pandemic in Sarawak?
2. How does the pandemic impact the personal and professional lives of nurses in Sarawak?

BACKGROUND OF STUDY

The term crisis originates from the ancient Greek word *krisis,* which denoted a decision or decisive turning point, particularly in relation to illness or legal judgment (Kamiński, 2024). In contemporary usage, a crisis signifies a critical and disruptive situation that threatens stability and requires immediate, coordinated action. Health crises such as pandemics, natural disasters, technological failures, and large-scale humanitarian emergencies have become increasingly frequent in the modern era, driven by globalization, climate change, rapid population movement, and widening socioeconomic disparities (Alrashidi et al., 2024). These events significantly strain healthcare systems, disrupt essential services, and contribute to profound physical, psychological, and socioeconomic consequences for communities.

The contemporary healthcare environment, characterized by economic pressures, rapid technological advancements, shifting demographics, and increasing chronic illnesses, presents growing complexities and stressors for nurses (Helne, 2018). Nursing practice, defined by compassionate and relational care combined with clinical expertise, exemplifies this holistic perspective of wellbeing (Fawaz et al., 2018; Peplau, 1988). However, recurrent infectious disease outbreaks and escalating healthcare demands have exacerbated existing professional challenges, increasing risks for burnout, job dissatisfaction, and reduced workforce resilience (Fawaz et al., 2018).

During a health crisis, the crucial role of nurses becomes particularly evident as they confront heightened uncertainty, surges in patient volume, resource limitations, and rapidly changing clinical demands. These conditions impose significant psychological and physical pressures, requiring nurses, often the first point of contact for patients, to quickly adapt to new protocols. In addition, nurses need to manage complex clinical and emotional needs while continuing to provide compassionate care despite personal risk. The COVID-19 pandemic exemplified these challenges on an unprecedented scale. Its high transmissibility and unpredictable clinical course placed immense strain on health systems worldwide (Paterson et al., 2022). As a result, nurses were positioned at the frontline, working prolonged shifts, navigating evolving guidelines, and facing continuous exposure to infection. They assumed expanded roles involving mass screening, stringent infection control, symptom management, public health education, and psychosocial support under prolonged work shifts and significant emotional burdens (Almaghrabi et al., 2020). Additionally, they had to manage intensive symptom management, often under resource constraints and with considerable emotional and physical fatigue.

These challenging conditions elevated stress, burnout, and physical and emotional exhaustion, undermining both personal well-being and professional effectiveness (Villar et al., 2021). Nurses in this context faced compounded stressors, balancing extensive professional responsibilities, including patient triage, treatment, and community health education, while experiencing physical separation from their families and traditional support networks (Newby et al., 2020). These compounded demands inevitably transformed their everyday routines, interpersonal

relationships, emotional well-being, and professional identities. This study delves deeply into nurses' lived experiences in a multicultural community in Sarawak who handle the pandemic while managing their personal lives. Although many global studies have investigated the multiple effects of nurses' well-being during the COVID-19 pandemic, limited empirical insights exist into how nurses navigated culturally specific stress responses, linguistic diversity, and disruptions to personal and family support systems.

METHOD

Study Design

This qualitative study adopts an interpretive phenomenological approach to achieve an in-depth understanding of phenomena through non-numeric data, emphasizing the description and explanation of relationships, individual experiences, and group norms (Moser & Korstjens, 2018; Oranga & Matere, 2023). Phenomenology, as articulated by Van Manen (1990), is particularly suited to explore the originality of human existence by revealing the essence of lived experience as it is consciously perceived. It focuses on understanding phenomena through individuals' personal awareness and the language they use to express their realities. This approach encourages thoughtful reflection on everyday life and contextualizes human actions within rich, meaningful frameworks.

Closely linked to hermeneutics, the art and science of interpretation, phenomenology enables researchers to uncover deeper, often implicit, meanings embedded within participants' narratives, particularly in complex and emotionally charged contexts such as a pandemic. Hermeneutic phenomenology goes beyond mere description to interpret the significance of experiences within cultural, social, and historical contexts, allowing for a richer understanding of how individuals make sense of their worlds (Alraisi et al., 2020).

Given that nursing is both a knowledge-based discipline and a professional practice deeply embedded in cultural, social, and economic contexts, hermeneutic phenomenology is especially appropriate for exploring profession-related phenomena. This method facilitates the disclosure of the complex meanings underpinning nursing knowledge and practice, capturing the nuanced realities of nurses' lived experiences. Moreover, the knowledge generated through this approach is inherently descriptive and exploratory, enhancing rich, deep insight into professional meaning-making processes and practical implications for nursing care (Alraisi et al., 2020).

Central to Van Manen's interpretive phenomenology are four fundamental existential dimensions of the lifeworld: the lived body, the lived space, the lived time, and the lived other. These existentials serve as foundational perspectives for understanding human experience in its fullness. Specifically, lived time (temporality) encompasses not only chronological time but also the emotional and psychological perception of time's passage. Lived space (spatiality) reflects individuals' subjective experience of their physical and social environments, influencing their emotional and psychological states. Lived body (corporeality) pertains to how people experience and relate to their own bodies as they interact with their surroundings. Finally, lived other (relationality) concerns the intersubjective experiences of relationships and social connections, including how individuals perceive, engage with, and are influenced by their interactions, support systems, and social roles.

Van Manen emphasizes that although these existentials can be examined individually, their dynamic interrelation constitutes the totality of an individual's lifeworld. Changes or disruptions in one dimension inevitably affect the others, shaping the holistic nature of lived experience (Van Manen & Van Manen, 2021). The application of this comprehensive framework in the present study provides nuanced insights into how nurses embody, perceive, and relate to their professional and personal experiences amid the multifaceted physical, emotional, and social challenges posed by the COVID-19 pandemic. It elucidates their embodied experiences, temporal perceptions, spatial contexts, and relational dynamics within the healthcare environment.

Sample and Setting

A purposive sampling strategy was employed to ensure diversity in seniority, age, and gender among participants. Using purposive sampling, a non-probability technique where participants are chosen based on particular traits or eligibility criteria (Khan et al., 2025). Inclusion criteria were registered nurses with at least 12 months of clinical experience who had worked in the COVID-19 isolation units and had provided direct patient care.

Ten nurses from the Infectious Disease (ID) ward at Sarawak General Hospital participated until data saturation was reached. Data saturation is defined as the point at which no new themes emerge from additional interviews (Morse, 2015). Regarding sample size in phenomenological research, Morse (1995) recommends six to ten participants to reach saturation. Creswell (2013) suggests a range of five to twenty-five participants, depending on the complexity of the phenomenon under investigation. Creswell and Creswell (2018) offer a broader guideline of ten to fifty participants, emphasizing that sample size should be determined in accordance with the research

questions and the specific focus of the study. Table 1 illustrates the characteristics of the ten nurses in this study. Their age range was 28 to 43 years, and they were of Chinese, Malay, and Bidayuh descent. Their professional experience ranged from 4 to 21 years, offering a broad perspective on how caring for COVID-19 patients affected their lives.

Table 1: Characteristics of the participants

Sample	Pseudonym	Gender	Age	Race	Work Experience
1	Laura	Female	43	Chinese	21 years
2	Naomi	Female	28	Malay	6 years
3	Amanda	Female	29	Bidayuh	4 years
4	Teresa	Female	38	Malay	12 years
5	Malik	Male	33	Bidayuh	9 years
6	Imran	Male	34	Malay	9 years
7	Felicia	Female	29	Bidayuh	4 years
8	Wendy	Female	31	Malay	9 years
9	Umaira	Female	36	Malay	14 years
10	Claudia	Female	41	Bidayuh	18 years

Data Collection

Following ethical clearance, eligible participants were purposively selected from nurses working in the Infectious Disease (ID) ward at Sarawak General Hospital (SGH). Participants who consented to take part were provided with detailed information about the study via a Participant Information Sheet (PIS) prior to the interviews. This process ensured that participants were fully informed about the research objectives, the nature of the information sought, confidentiality measures, and their right to withdraw at any time without justification. Permission to digitally audio-record the interviews was also obtained before commencement.

Interviews were scheduled during participants' working hours, ideally after doctors' rounds and when no major procedures were underway, to minimize interruptions and ensure a conducive environment for open dialogue. Building trust and rapport was considered essential to eliciting genuine, rich accounts from the participants. The researcher's prior experience as a nurse in the same hospital facilitated this rapport, providing insight into the clinical environment and fostering empathy and connection with participants.

Data collection occurred from March to June 2021 through face-to-face, in-depth individual interviews conducted using a semi-structured interview guide. This guide was adapted with permission and subsequently reviewed by a panel of nursing educators and qualitative research experts. Feedback from this expert panel was incorporated to enhance clarity, relevance, and comprehensiveness.

Each interview lasted approximately 45 to 60 minutes and was audio-recorded with consent, then transcribed verbatim and anonymized to maintain confidentiality. Interviews commenced with open-ended prompts aimed at building rapport and encouraging spontaneous narratives, such as:

> *"... My name is ..., and I would like to ask you some questions about your experiences working during the COVID-19 pandemic in Sarawak. Please briefly tell me about yourself and your background."*

As Cleland (2017) emphasises, the interview questions were tailored to each participant, encouraging detailed, descriptive responses rather than simple affirmations. The researcher adopted a non-intrusive, attentive stance, intervening only to seek clarification or encourage more profound reflection.

Subsequent questions probed into the complexities of patient care, workplace conditions, and personal challenges. Prompts such as *"What motivated you to continue working during the crisis?"* and "*What concerns did you have about working during a pandemic?"* invited participants to reflect deeply on the meanings embedded in their experiences. The researcher employed probing techniques, asking "how" and "why" questions to facilitate elaboration and nuanced insight, adapting flexibly to each participant's communication style. This flexible and participant-centred interview approach enabled nurses to articulate their lived realities authentically, providing a comprehensive understanding of the psychosocial impact of the COVID-19 pandemic on frontline nursing staff, including their professional challenges, emotional resilience, and coping strategies.

Ethical Considerations

This study received ethical approval from the National Medical Research Registry and formal permission from hospital administration and the Infectious Disease (ID) ward. Participants provided written informed consent after understanding the study objectives, their right to withdraw at any time, and confidentiality assurances. Anonymity was preserved by assigning unique identifiers to each participant, and all data were securely stored to protect privacy. To safeguard participants' well-being, they were informed of the potential emotional impact of the interviews and reminded of their right to decline any question or terminate the interview at any point. Throughout the data collection process, the researcher employed therapeutic communication techniques to create a safe and supportive environment, ensuring that any emotional difficulties arising during interviews were handled with sensitivity and professionalism.

Measures to enhance trustworthiness

This study ensured rigor and trustworthiness by adhering to Lincoln and Guba's (1986) established criteria, which include credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with participants, enabling the researcher to build rapport, gain deeper insights, and validate emerging findings during data collection. Member checking was also conducted by sharing transcripts and preliminary interpretations with participants to confirm accuracy and resonance with their experiences. Dependability was ensured by maintaining a comprehensive audit trail documenting all methodological decisions, data collection procedures, coding processes, and analytical steps. This transparent record allows for replication and external examination of the research process. Confirmability was strengthened through continuous researcher reflexivity. The researcher maintained reflective journals to acknowledge and bracket personal biases and assumptions, thereby ensuring that findings were grounded in participants' perspectives rather than the researcher's preconceptions. Transferability was supported by providing rich, detailed descriptions of the study context, participants' characteristics, and the research setting. These thick descriptions enable readers to evaluate the applicability and relevance of the findings to other similar healthcare environments or cultural contexts.

DATA ANALYSIS

Thematic analysis was employed to systematically code and categorize the data, enabling the identification of patterns and the development of themes that represent shared experiences while acknowledging individual variations. This approach aligns with Van Manen's (1984) Model of Phenomenological Process, which emphasizes the exploration of experience through reflective interpretation. Braun and Clarke's (2006) six-phase framework guided the thematic analysis, ensuring a rigorous and transparent analytical process. The initial phase involved repeated, immersive reading of interview transcripts to facilitate deep familiarization with the data and generate preliminary ideas. This step was essential for capturing the depth and nuance of participants' psychosocial narratives. Subsequently, inductive manual coding was conducted to identify meaningful units of text related explicitly to nurses' psychosocial experiences during the COVID-19 pandemic. Manual coding was chosen to enhance researcher engagement with the data, allowing close interpretation of contextual subtleties and preserving the integrity of participants' accounts. The generated codes were then systematically collated into preliminary themes that reflected coherent, recurrent patterns within the dataset. Throughout this process, special attention was given to maintaining contextual richness and honouring the complexity of individual experiences while identifying shared elements. Theme refinement and validation were achieved through an iterative process involving two researchers who critically reviewed and compared the emerging themes against the original transcripts. This collaborative approach ensured internal consistency, clarity, and thematic distinctiveness, minimizing subjective bias and enhancing analytic trustworthiness.

Once finalized, themes were clearly defined and named to encapsulate their core meanings and relevance to the research objectives. To deepen the interpretive quality, the analytic process incorporated Van Manen's lifeworld existentials—lived body, lived space, lived time, and lived other as a theoretical lens. This two-stage approach combined descriptive thematic identification with existential interpretation, facilitating a structured yet richly nuanced understanding of nurses' psychosocial realities during the pandemic, integrating phenomenological insight with thematic rigor, illuminated not only the tangible challenges nurses faced but also the profound meanings ascribed to their lived experiences, contributing to a holistic portrayal of nurse wellbeing amid crisis.

RESULTS

From the thematic analysis, three themes emerged: Adapting to Workplace Challenges, Strengthening Camaraderie in the Healthcare Environment, and Upholding Commitment and Professionalism During the Challenges. Theme 1 is further sub-divided into three (3) sub-themes: Determining Role Expectations, Mitigating Regulatory Constraints, and Cultivating Affinity in a Restricted Environment. Similarly, Theme 2 is also

subdivided into two (2) sub-themes: Finding Belonging and Purpose and Building Multi-Dimensional Camaraderie. Theme 3 also has four (4) sub-themes: Embodying a Sense of Duty, Confronting Physical and Emotional Obstacles, Practising Self-Stewardship, and Experiencing Discrimination and Inequality. Table 2 summarizes the themes and sub-themes in this study.

Table 2: Themes and Sub-themes from this Study

Themes	Sub-Themes
Theme 1: Adapting to Workplace Challenges	Sub-Theme .11: Determining Role Expectations Sub-Theme 1.2: Mitigating Regulatory Constraints Sub-Theme 1.3: Cultivating Affinity in a Restricted Environment
Theme 2: Determining Role Expectations, Mitigating Regulatory Constraints, and Cultivating Affinity in a Restricted Environment	Sub-Theme 2.1: Finding Belonging and Purpose Sub-Theme 2.2: Building Multi-Dimensional Camaraderie
Theme 3: Upholding Commitment and Professionalism During the Challenges	Sub-Theme 3.1: Embodying a Sense of Duty Sub-Theme 3.2: Confronting Physical and Emotional Obstacles Sub-Theme 3.3: Practising Self-Stewardship Sub-Theme 3.4: Experiencing Discrimination and Inequality

Theme 1: Adapting to Workplace Challenges
The nurses in this study demonstrated remarkable adaptability despite facing unprecedented clinical, emotional, and organizational pressures during the COVID-19 pandemic. Their capacity to adjust and persist through evolving demands highlights their resilience and professional flexibility.

Sub-theme 1.1: Determining Role Expectations
Participants experienced considerable emotional strain stemming from fixed yet often ambiguous role expectations. The uncertainty surrounding their responsibilities, coupled with a perception that their substantial efforts were frequently overlooked or undervalued, contributed to feelings of frustration, helplessness, and diminished professional self-worth. Claudia (P10) vividly expressed this emotional burden, stating,

> *"At times tears come out… What we are doing is nothing, but the work is half-dead."*

Such statements reflect the psychological stress and emotional exhaustion resulting from unclear role boundaries, overwhelming workloads, and insufficient recognition. Similarly, Laura (P1) recounted the initial challenges during the establishment of the COVID-19 ward, noting tensions among staff:

> *"When the COVID-19 ward was newly set up, some staff were angry, as some did not want to take care of COVID-19 patients. There was stress, and even conflicts. If the PPE supply was inadequate, arguments arose among staff. 'Where to find it?' The doctor was frustrated, asking, 'Why aren't all the items there?' This was the first time COVID-19 appeared in Malaysia, after all."*

These accounts underscore the heightened stress and interpersonal strain engendered by rapidly evolving roles and resource limitations during the pandemic.

Sub-theme 1.2: Mitigating Regulatory Constraints
Frequent, abrupt changes to protocols and procedures throughout the pandemic generated considerable confusion among nurses, undermining their ability to confidently acquire and apply new practices. This persistent uncertainty impeded nurses' efficiency and effectiveness, complicating patient care and elevating stress levels. Wendy (P8) articulated these challenges:

> *"You haven't mastered certain things yet, then there are new things… 'Which one now? … For example, when sending the lab sample, for a second, it says like this, then it says like that, so we are confused."*

Similarly, Imran (P6) highlighted the necessity of continual adaptation to evolving guidelines:

> *"... we just got to know the disease; we will follow the guidelines provided. Maybe tomorrow there will be a new guide that we can follow, a better one. For now, we just follow."*

Amanda (P3) further emphasized procedural restrictions imposed on staff presence within patient rooms:

> *"... when you go inside, you want to wait for everything to finish before exiting from the patient's room. At that time, the rules were that only staff nurses were allowed to go into a patient's room."*

The inconsistency and rapid evolution of guidance exacerbated anxiety and eroded professional confidence, highlighting the challenges nurses faced in maintaining safe and effective care under regulatory constraints.

Sub-theme 1.3: Cultivating Affinity in a Restricted Environment
Physical separation from family and friends compelled nurses to rely heavily on digital communication as a vital coping strategy. Video calls, social media, and instant messaging platforms were frequently used to maintain emotional connections, seek support, and temporarily alleviate stress. Laura (P1) highlighted the emotional importance of these interactions, stating,

> *"My daughter video-calls me every day, I'm staying at the hostel… I answer: 'Later, mum is busy now."*

Similarly, Naomi (P2) described how she used digital communication to reassure her concerned mother:

> *"... at first, my mother was extremely worried. My mom always calls to say hello. I keep saying I'm okay because I don't want her to worry too much. If I always say, 'I'm okay,' mom will call me less frequently. Mom used to call every day to ask if I was alright and remind me to take care of my health. I said I was okay even though I wasn't at that time."*

These accounts demonstrate how technology effectively bridged the emotional distance imposed by strict isolation measures, thereby sustaining nurses' psychological well-being during challenging circumstances.

Theme 2: Strengthening Camaraderie in the Healthcare Environment
The collective experience of adversity among nurses during the pandemic significantly enhanced camaraderie, mutual support, and emotional resilience within healthcare teams.

Sub-theme 2.1: Finding Belonging and Purpose
Amid intense pressures, nurses cultivated profound feelings of solidarity, shared purpose, and mutual respect within their teams. These relational bonds served as vital sources of emotional support and reinforced their professional commitment. Wendy (P8) succinctly expressed this collective spirit:

> *"We go in together, come out together—hard times and happy times."*

Such a sense of unity strengthened resilience and sustained morale, even under the most challenging circumstances. Teresa (P4) further highlighted the emotional depth of these connections:

> *"... Crying together. People won't understand how we feel. We are the ones in this together, so we know the feeling. Even during shift handovers, some nurses cry while writing reports. We remain silent and wait for her to finish crying before we continue."*

These testimonies illustrate how shared experiences fostered a sense of belonging and purpose, helping nurses endure the emotional demands of their roles.

Sub-theme 2.2: Building Multi-Dimensional Camaraderie
Support networks extended beyond immediate colleagues, incorporating family members, organizational leadership, and broader community involvement. Such multi-dimensional relationships formed a crucial emotional and social safety net for nurses. Imran (P6) noted the significance of familial encouragement:

> *"My wife and parents always give advice and encouragement."*

Wendy (P8) appreciated peer support profoundly, stating:

> *"Kak S was the one who supported me… she kept reminding me, 'Be patient, maybe there is light at the end of the tunnel."*

Additionally, tangible gestures from organizational leadership, such as vitamins and traditional nourishing foods, provided a sense of appreciation and care. Teresa (P4) recalled these gestures positively:

> *"Dr T gave us vitamins… sometimes she even bought bird's nest for the staff."*

Such acts underscored organizational recognition and nurtured a supportive work environment.

Theme 3: Upholding Commitment and Professionalism During the Challenges
Despite multifaceted, ongoing difficulties, nurses maintained exceptional levels of professional commitment, demonstrating unwavering dedication to their roles and responsibilities.

Sub-theme 3.1: Embodying a Sense of Duty
Participants perceived nursing not merely as a profession but as a moral responsibility, or "*amanah,*" which underpinned their unwavering dedication despite personal risk. Imran (P6) clearly articulated this intrinsic motivation:

> *"… we think back, we help people, we don't want to give up just like that. It's a nurse's job to help patients, it's our duty. Think about who else would do it. We are assigned to do it; we are destined to be nurses."*

Similarly, Claudia (P10) encapsulated this profound sense of duty, stating:

> *"… we help people, even though we do not know if we will remain safe later; it is like a reciprocal act of kindness."*

This deeply ingrained commitment sustained their professional engagement and ethical resolve throughout the crisis.

Sub-theme 3.2: Confronting Physical and Emotional Obstacles
Nurses experienced considerable physical demands, including prolonged shifts, heavy patient loads, and physically strenuous tasks, often exacerbated by limited staffing and resources. Felicia (P7) described the physically taxing aspect of patient care vividly:

> *"If a patient died, only two nurses could do the last office (LO). When the patient is large, placing them in the sealed bag causes backache. I'm thin, and the patient was heavy."*

Emotional strains, such as interpersonal conflicts intensified by team divisions, also impacted morale. Wendy (P8) noted interpersonal challenges:

> *"As colleagues, we did have clashes… splitting into teams created smaller groups—some became selective about partners. But working 12-hour shifts together through ups and downs improved strained relationships."*

These reflections highlight the dual physical and emotional tolls nurses navigated daily.

Sub-theme 3.3: Practising Self-Stewardship
Balancing professional responsibilities alongside personal, financial, and spiritual well-being emerged as a vital component of resilience among participants. Spiritual perspectives, in particular, were emphasized as essential coping mechanisms. Naomi (P2) described nursing as both a livelihood and a source of spiritual fulfillment:

> *"… this is our job, our source of sustenance. If I don't work, I won't receive a salary. I have commitments such as a car, a house, and supporting my family. I believe this is the primary reason I continue. Moreover, receiving 'pahala' (reward from God) motivates me to come to work."*

Such spiritual beliefs played a critical role in maintaining emotional equilibrium and reinforcing professional commitment. Naomi also highlighted the significance of mutual support among housemates during quarantine, sharing how they assisted one another by providing necessities:

> *"When a friend feels down and is quarantined due to contact with a patient, we provide support. For example, if she is quarantined at home, we help by delivering food and leaving it at the fence."*

These practices of self-stewardship and communal care contributed significantly to sustaining nurses' wellbeing during the pandemic.

Sub-theme 3.4: Experiencing Discrimination and Inequality
Participants reported encountering inequitable workload distribution and biases rooted in hierarchical structures and marital status. Single nurses were frequently assigned a disproportionate share of high-risk tasks, based on assumptions about familial obligations. Wendy (P8) remarked,

> *"Usually, singles are nominated to care for such patients… married people have families."*

Teresa (P4) corroborated this experience, noting,

> *"… the first to be involved in caring for COVID-19 patients are mostly nurses who are single. The superiors tend to select single staff first."*

These systemic inequalities engendered feelings of unfairness, dissatisfaction, and reduced morale, highlighting the urgent need for more equitable organizational policies and practices.

DISCUSSION

The COVID-19 pandemic exerted a profound existential influence on nurses' lived experiences, permeating their professional roles, personal lives, and social relationships. Interpreted through Van Manen's four existential life worlds — lived body, lived space, lived time, and lived other — the findings reveal the complex, multidimensional impact of this global health crisis on nursing practice and wellbeing (Table 3).

Table 3: Interpretation using Van Manen's Four Existential Lifeworlds

Van Manen's Lifeworld	Mapped Themes and Sub-Themes	
Lived Body (Corporeality)	Theme 3: Upholding Commitment and Professionalism During the Challenges	Sub-theme 3.1: Embodying a Sense of Duty Sub-theme 3.2: Confronting Physical and Emotional Obstacles Sub-theme 3.3: Practising Self Stewardship
Lived Space (Spatiality)	Theme 1: Adapting to Workplace Challenges	Sub-theme 1.3: Cultivating Affinity in a Restricted Environment
Lived Time (Temporality)	Theme 1: Adapting to Workplace Challenges	Sub-theme 1.1: Determining Role Expectations Sub-theme 1.2: Mitigating Regulatory Constraints
Lived Other (Relationality)	Theme 2: Strengthening Camaraderie in the Healthcare Environment	Sub-theme 2.1: Finding Belonging and Purpose Sub-theme 2.2: Building Multi-Dimensional Camaraderie
	Theme 3: Upholding Commitment and Professionalism During the Challenges	Sub-theme 3.4: Experiencing Discrimination and Inequality

Lived Body (Corporeality)
Nurses' embodied experience during the pandemic was marked by heightened physical vulnerability and discomfort. Prior to COVID-19, the body served as a reliable and skilled instrument of caregiving; however, the pandemic disrupted this normalcy. The imposition of extensive personal protective equipment (PPE) presented

significant physical barriers, restricting mobility and inducing skin injuries, discomfort, and fatigue. This aligns with Galehdar et al. (2020) and Rathnayake et al. (2021), who documented the corporeal toll of prolonged PPE use among frontline nurses.

Felicia's description of musculoskeletal strain from handling heavy patients underlines the severe physical demands intensified by understaffing and resource limitations, a situation echoed internationally during pandemic surges. Moreover, the transformation of touch from a therapeutic gesture to a potential vector of infection reconfigured nurses' embodied relationality with patients, adding emotional complexity to the physical burden.
Emotionally, nurses reported feelings of exhaustion and frustration, encapsulated in Claudia's "half-dead" expression, reflecting the interplay between corporeal strain and psychological distress. The dual burden of physical fatigue and emotional depletion underscores the inseparability of body and mind in lived experience.
Importantly, nurses engaged in self-stewardship by nurturing physical, emotional, and spiritual well-being, often drawing on cultural and religious frameworks such as *amanah* (moral trust) and *pahala* (spiritual reward). This spiritual resilience, consistent with findings by Deliktas et al. (2021) and Tamayo et al. (2024), served as a vital resource enabling sustained professional dedication despite personal risk and hardship.

Lived Space (Spatiality)
The pandemic radically transformed nurses' spatial worlds, fragmenting previously familiar environments and reshaping relational geographies. The hospital, once a site of structured care and collegial collaboration, became a fragmented, high-risk space governed by strict infection control measures. The ubiquitous presence of PPE and social distancing protocols fostered an atmosphere of isolation and emotional strain, altering nurses' perceptions of their workplace from a community hub to a zone of vigilance and uncertainty. These changes corroborate findings by Segev (2022) and Liang et al. (2021), who observed spatial dislocation and moral strain among healthcare workers in crisis contexts.

Simultaneously, the home environment, traditionally a sanctuary, was compromised by fears of viral transmission, prompting many nurses to isolate themselves in dormitories or hostels. Although initially experienced as alienating, these shared living spaces evolved into micro-communities of support, fostering solidarity amid adversity. Such spatial adaptations highlight the fluidity of "home" and the creative strategies nurses employed to negotiate safety, belonging, and emotional sustenance (Muz & Erdoğan, 2021).

Moreover, digital spaces emerged as critical sites of emotional connection. Through video calls and instant messaging, nurses maintained vital ties to family and friends, mitigating the psychological impact of physical separation. This virtual connectivity blurred boundaries between clinical, residential, and social spaces, underscoring the expanding role of technology in shaping lived space and supporting wellbeing during crises.

Lived Time (Temporality)
The pandemic's relentless demands profoundly disrupted nurses' temporal experience. Pre-pandemic rhythms, characterized by predictable shifts and routines, were supplanted by an exhausting, disorienting present marked by extended twelve-hour shifts, incessant patient care, and continuously evolving protocols. This temporal distortion engendered a sense of time both dragging and accelerating, reflecting the psychological strain of sustained crisis work and uncertainty about the future.

The shared temporal rhythms of team-based work, symbolized in Wendy's expression "We go in together, come out together," provided crucial temporal anchors fostering solidarity and collective resilience. This collective temporality not only sustained morale but also helped reconstruct a sense of continuity and purpose amid chaos.
Additionally, the pandemic prompted nurses to reflect on their professional identities and life trajectories. Some reconsidered career aspirations, seeking improved work-life balance or coping with emotional exhaustion, while others reported strengthened vocational commitment. These divergent temporal reflections align with Thrysoee et al. (2022) and underscore how lived time shapes evolving professional self-understanding during protracted crises.

Lived Other (Relationality)
Relational bonds emerged as foundational in sustaining nurses through the pandemic's challenges. Shared adversity forged deep camaraderie among colleagues, enhancing collective identity and emotional resilience. This sense of "being in it together" provided a critical buffer against isolation and burnout, consistent with Noviana et al. (2022). Beyond peer relationships, encouragement from family and organizational gestures such as the provision of vitamins and nourishing foods created a multilayered support system that affirmed nurses' value and care. Digital communication further bridged physical separation, facilitating emotional connection and well-being.

However, relational experiences were also constrained by entrenched hierarchical structures within Malaysia's healthcare system. In a high power-distance culture (Hofstede, 2011), the authority is rarely questioned, and decision-making remains centralized (Shariff et al., 2010). This culture often requires flatter hierarchies and greater employee autonomy (Thoemmes & Liu, 2025). Consequently, junior and single nurses were disproportionately assigned high-risk tasks, justified by assumptions about familial obligations, which exacerbated perceptions of inequity and reduced autonomy. This systemic inequity undermines morale and professional agency, reflecting cultural norms of deference and gendered expectations within nursing (Harun et al., 2020; Summers et al., 2014).

Furthermore, Malaysia's multicultural and religious context shapes relational dynamics, with Islamic leadership principles emphasizing respect for authority and moral integrity (Haq, 2020). While fostering order and accountability, such norms may inadvertently discourage junior nurses from voicing concerns or advocating for equitable practices. Addressing these cultural and organizational challenges is essential to promoting professional empowerment and fairness.

CONCLUSION

As a nurse educator and researcher, this study highlights the profound psychosocial impact of the COVID-19 pandemic on nurses' well-being and professional practice. Nurses demonstrated exceptional adaptability, resilience, and commitment despite significant workplace pressures, emotional burdens, and personal sacrifices. Key areas identified for improvement include clarifying role expectations, ensuring consistent regulatory guidance, providing comprehensive psychosocial support, and implementing equitable workplace policies. The findings emphasize the importance of strengthening team camaraderie and recognizing nurses' intrinsic motivation and spiritual resilience as critical factors in supporting their professional endurance. Ultimately, this study provides valuable insights for nurse education, healthcare policy, and leadership, underscoring the need for comprehensive strategies that safeguard nurses' holistic well-being and enhance the healthcare system's preparedness for future public health emergencies.

IMPLICATION OF THE STUDY

This study presents multifaceted implications that are critically relevant to healthcare practice, policy, education, and research, particularly in the context of public health crises such as the COVID-19 pandemic. Primarily, the findings emphasize the need to prioritize nurse well-being as a fundamental pillar of effective healthcare delivery. Safeguarding nurses' physical, psychological, social, and spiritual health is essential not only for their individual welfare but also for maintaining workforce resilience and ensuring the provision of safe, high-quality patient care. Healthcare institutions must consistently provide adequate personal protective equipment (PPE) and maintain safe clinical environments to mitigate occupational hazards and protect nurses from physical harm (Rathnayake et al., 2021).

The study also highlights the importance of culturally sensitive interventions that honor nurses' diverse backgrounds and spiritual beliefs. Within multicultural contexts such as Malaysia, integrating cultural and spiritual values like "*amanah"* (moral trust) and "*pahala"* (spiritual reward) into wellbeing programs can enhance intrinsic motivation, professional commitment, and psychological resilience (Liu et al., 2022; Tekke et al., 2020). Recognizing these spiritual dimensions within holistic wellbeing frameworks fosters emotional equilibrium and sustains vocational endurance (Liu et al., 2022).

Addressing systemic workplace challenges is critical. Role ambiguity, frequently changing protocols, hierarchical power structures, and inequitable workload distribution negatively impact nurses' experiences. Transparent and consistent communication, empathetic leadership, and equitable organizational policies are necessary to empower nurses, promote professional autonomy, improve job satisfaction, and reduce burnout (Chau et al., 2021; Demir & Şahin, 2022). Additionally, culturally sensitive psychological safety must be cultivated to overcome communication barriers rooted in values such as group harmony and face-saving prevalent in Asian contexts (Liu et al., 2022).

Adaptive strategies, including flexible scheduling, enhanced clinical and rest facilities, accessible mental health services, and comprehensive psychosocial support, are essential for fostering supportive work environments (Abdul-Mumin et al., 2023; Chau et al., 2021). The use of digital technologies to maintain social connectivity and provide emotional support is increasingly critical, particularly when physical distancing limits face-to-face interactions (Rathnayake et al., 2021).

Promoting self-care behaviours such as sufficient sleep, balanced nutrition, regular physical activity, mindfulness, and nurturing social connections further supports nurses' psychological resilience amid ongoing stressors (Abdul-Mumin et al., 2023; Chau et al., 2021; Sun et al., 2020). Wellbeing initiatives must also acknowledge and integrate religious and spiritual practices, which substantially contribute to psychological endurance and reaffirm nurses' vocational commitment (Liu et al., 2022).

LIMITATION OF STUDY

The qualitative nature of this study, combined with purposive sampling and a small sample size, restricts the breadth of perspectives and limits the generalizability of the findings beyond the specific context of Sarawak General Hospital. Additionally, reliance on self-reported data collected through interviews may introduce recall bias or social desirability bias, potentially affecting data accuracy. Future research should consider employing larger sample sizes and longitudinal designs to more comprehensively explore the evolving impacts of pandemics on nurses' well-being and their personal and professional lives over time.

RECOMMENDATIONS TO THE STUDY

From an educational and research perspective, these findings advocate for embedding culturally informed wellbeing frameworks into nursing curricula and continuing professional development. Future research should evaluate the effectiveness of such interventions and examine the long-term impact of pandemic-related stressors on nurses' well-being and retention. Overall, this study advocates for an integrated, culturally informed, and systemic approach to nurse wellbeing, one that promotes individual resilience, strengthens workforce capacity, and enhances healthcare systems' preparedness and responsiveness to future public health challenges.

Healthcare institutions should strengthen nursing practice by prioritizing nurses' physical, psychological, social, and spiritual well-being. This includes providing consistent PPE supply, maintaining safe clinical environments, and ensuring clear communication of clinical protocols. Empathetic leadership, equitable workload distribution, and culturally sensitive support, such as acknowledging values like *amanah* and *pahala*, can further enhance motivation, autonomy, and resilience among nurses. Nursing practice should also integrate practical wellbeing supports such as flexible work scheduling, adequate rest areas, peer support, and accessible mental health services. Encouraging self-care, mindfulness, and healthy lifestyle habits, as well as using digital platforms to maintain social connections, can help nurses manage stress during crises. Together, these strategies promote sustained resilience and enable nurses to provide safe, compassionate, and high-quality care.

AUTHOR CONTRIBUTION

The authors confirm their contribution to the paper as follows: The study conception and design were conducted by CAL and RVB. Data collection and draft manuscript preparation were done by CAL, while CAL and RVB did the analysis and interpretation of results. Both authors reviewed the results and approved the final version of the manuscript.

FUNDING STATEMENT

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

ACKNOWLEDGEMENT

The researchers would like to thank the nurses who participated in the interview and express high respect for nurses' hard work during the COVID-19 pandemic.

DECLARATION OF CONFLICTING INTEREST

The authors declared no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

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