

Intensive Care Nurses' Anxiety About COVID-19, Approaches to and Attitudes Toward Dying with Dignity Principles During the Pandemic

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Abstract

While trying to protect themselves from COVID-19, intensive care nurses saved many patients by providing care during the pandemic. The aim of this study is to determine the anxiety levels of nurses working in intensive care units about COVID-19, attitudes toward and approaches to end-of-life care, and attitudes toward dying with dignity. This cross-sectional descriptive study was carried out with 144 nurses. The Attitudes and Behaviors of ICU Nurses Intended for End-of-Life Care Scale, Attitudes towards Principles about Dying with Dignity Scale and COVID-19 Anxiety Scale were used to collect data. The mean age of the nurses was 30.02 ± 6.02 . 63.80% of them were women and 62.20% of them worked in the internal intensive care unit. While the participants supported the principles of dying with dignity, their attitudes and approach to end-of-life care were at a good level, and COVID-19 anxiety was at a low level. Participants mostly adopted the protection of human dignity and privacy principles.

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Attitudes and approaches to end-of-life care and attitudes toward dying with dignity were not affected by COVID-19 anxiety.

Keywords

death, end-of-life care, dignity, nurse

Introduction

The ongoing COVID-19 pandemic has caused serious burdens to the health system and health professionals, bringing the need for physical and psychosocial support to the agenda (Artan et al., 2020). During this time, nurses, especially in intensive care units (ICUs), who took an active role in the health team experienced difficulties due to intense work hours, limited opportunities, ambiguities, contagion anxiety, frequent losses, and isolation (Habibzadeh et al., 2020; Galehdar et al., 2020; Gao et al., 2020). During the pandemic, nurses serve patients in intensive care units, some of whom are in the last stages of their lives. It is important to give the best service to the patient during this stage. To maintain the best possible service while protecting the rights of the patient in end-of-life care is among the responsibilities of the nurse. In the literature, expressions such as “good death,” “peaceful death,” “proper death,” “desired death,” or “dying with dignity” are sometimes used synonymously and sometimes differently (Meier et al., 2016; Kastbom et al., 2017; Krikorian et al., 2020). What patients think of as “good death” is strongly influenced by culture, religion, age, living conditions, illness, and financial problems (Krikorian et al., 2020). The aim of “dying with dignity” is to prevent the person from experiencing unnecessary stress, to reduce their pain and suffering, to not expose them to traumatic treatment interventions, and to make them feel valuable (Aslan & Dundar, 2020; Köse et al., 2019).

Anxiety is expressed as a cognitive component, which is difficult to explain and causes discomfort (Morosanova et al., 2019). Anxiety is a source of distress, especially when the nature of the threat is not well understood, its manifestation is uncertain, and individuals feel they have little control over the onset or termination of stress. Health anxiety is a function of the perception of how likely and how severe a feared illness is (Çiçek & Almalı, 2020).

Nurses face ethical problems in end-of-life care. It is important to know the nurses' attitudes and perceptions toward death and dying with dignity in the healthy execution of this care. Hold (2017) emphasized that in end-of-life care quality of life is a fundamental problem, and symptom management is important. In addition, situations where a patient's relative intervenes with care affect patient autonomy and cause serious ethical problems. Hold (2017) also stated that nurses play a key role in solving these problems, but they face difficulties. In the current healthcare system focused to save lives, nurses have difficulty talking about death-related issues and are faced with a dilemma between saving lives and supporting “good death.” While intensive care

nurses work in difficult conditions during the pandemic, COVID-19 can increase death anxiety (Kavaklı *et al.*, 2020).

During the pandemic, all patients in the intensive care unit were given care with strict restrictions due to the risk of transmission of the virus. On one hand, nurses worried about catching the disease while providing care, on the other hand, they continued to provide health services to dying patients with special equipment (Chochinov *et al.*, 2020; Liang *et al.*, 2021; Riello *et al.*, 2020) and encountered dying patients frequently (Arcadi *et al.*, 2021; Chochinov *et al.*, 2020). According to Chochinov *et al.* (2020), distress caused by symptoms, not feeling valuable, or respected can damage the dignity of a dying patient. The damage caused by the virus affects the patient in an unusually way physically and emotionally during the last period. Therefore, the anxiety of contagion of the disease causes the nurse to face the anxiety of death in this process. The fear and anxiety caused by a contagious disease can be devastating if not defined and managed properly (Riello *et al.*, 2020; Zhang *et al.*, 2020), and may cause difficulty in understanding the patient and managing the process negatively when caring for a terminally ill patient. Therefore, it is important for nurses to manage the care process correctly and to carry out the service by being aware of their own feelings about respectable death.

End-of-life care in the ICU occurs more frequently during the pandemic. Attitudes and behaviors toward end-of-life care given in the ICUs may be affected by the attitude toward death and experiencing COVID-19 anxiety. This study was planned to determine ICU nurses COVID-19 anxiety, end-of-life care attitudes and approaches, and attitudes toward dying with dignity.

Methods

Type of Research

This is a cross-sectional and descriptive study.

Location and Characteristics of the Research

The study was carried out with nurses working in intensive care units of a university hospital.

Universe of the Research

The universe of the study consisted of 250 nurses working in the intensive care units of a university hospital in Turkey.

Sample of the Research

The sample size of the study was determined as a minimum of 138 ICU nurses using Epi Info StatCalc program in order to have a moderate relationship between the two scales (0.50) to be statistically significant, Type I error as 0.01, and the power of the test was 95.00%. The study constituted a sample of 144 nurses who met the inclusion criteria. No sample selection method was not used; nurses working in the intensive care unit who agreed to participate in the research after being informed about the study were included in the study; those who did not meet these criteria were excluded.

Data Collection

The data were collected from the nurses who met the inclusion criteria and agreed to participate in the study between February 10, 2021, and June 10, 2021. The researchers distributed and collected the questionnaires in person. Data collection form was filled in 17–20 minutes.

Data collection form: This form was created by the researchers after scanning the literature (Aslan & Dundar, 2020; Özel Yalçınkaya, 2016; Sakaoğlu et al., 2020). In this section, there are 12 questions to determine the participants' socio-demographic characteristics, status of having COVID-19, COVID-19 anxiety levels, frequency of encountering the death process, and willingness to work in the ICU.

The Attitudes and Behaviors of ICU Nurses Intended for End-of-Life Care

The validity and reliability study of the scale developed by Zomorodi in 2008 was carried out by Özel Yalçınkaya (2016). The five-point Likert type scale consists of 2 sub-dimensions and 16 items: attitude sub-dimension has 10 items, and the behavior sub-dimension has 6 items. Higher scores indicate that the attitude/behavior will be positive. The Cronbach's alpha internal consistency coefficient of the scale was $\alpha = 0.70$, attitude sub-dimension was 0.71, and behavior sub-dimension was 0.65 (Özel Yalçınkaya S, 2016). In our study, the Cronbach alpha internal consistency coefficient for the attitude toward end-of-life care was $\alpha = 0.784$, and for the Approach to end-of-life care was $\alpha = 0.802$.

Coronavirus Anxiety Scale: Lee developed this scale (2020) and Akkuzu et al. (2020) conducted the validity and reliability study. The scale has a single factor structure, consists of five items, and is scored between 0 and 4. A high score indicates high anxiety levels. The Cronbach alpha internal consistency coefficient was $\alpha = 0.93$ (Akkuzu et al., 2020). In our study, it was $\alpha = 0.911$.

Attitudes towards Principles about Dying with Dignity (ASAPDD). This five-point Likert type scale developed by Duyan (2014) consists of 12 items. Scores obtained from the scale vary between 12 and 60. However, the calculations were made by taking the average of the total number of items. When the average is multiplied by the total item number of 12, it is seen that the average score is in this range.

High scores indicate a high level of adoption of dying with dignity principles. The Cronbach alpha coefficient of the scale was calculated as 0.89 (Duyan, 2014). In our study, it was $\alpha = 0.921$.

Ethical Aspect of Research

Permission was obtained from the ethics committee of the university where the research was conducted (Date: 03/02/2021 No: 03/98). Also, institutional permission was obtained from the chief physician of the university hospital where the research was conducted (Date: 20/02/2021 Number: E-1582222). Before data collection, a written informed consent was obtained from the participants after the purpose of the research in accordance with the Helsinki Declaration was explained. Also, participants were informed about the fact that their participation is voluntary, and their answers will be kept confidential and evaluated only as scientific data.

Data Analysis

Statistical analyses were performed using the IBM SPSS Statistics Free Download package program. The Cronbach's alpha test was used to evaluate the internal consistency and the cut-off value was ≥ 0.70 . Necessary calculations were done by taking the average of the Likert type scales. Kolmogorov-Smirnov normality test was applied to the data. Mann-Whitney test, a nonparametric test, was used in pairwise comparisons, and Kruskal-Wallis test was used in comparisons with more than two groups. Spearmans Correlation was used to examine the relationships between scales, subgroups and other variables. In addition, descriptive statistics are given. $p < .05$ was considered significant in statistical tests.

Results

The mean age of the participants was 30.02 ± 6.02 , 63.80% ($n = 81$) of the participants were female, and 50.40% ($n = 64$) were married. 8.70% ($n = 11$) of the participants were medical vocational high school graduates, whereas 91.30% ($n = 116$) had undergraduate/graduate degrees.

62.20% ($n = 79$) of the nurses worked in the internal intensive care unit, 26.80% ($n = 34$) in the surgical intensive care unit, and 11.00% ($n = 14$) in the pediatric intensive care unit. The average years worked in the profession was 6.86 ± 5.86 years and in the ICU was 4.90 ± 4.36 years. 37.00% ($n = 47$) of the participants reported the frequency of encountering a patient who is in the process of dying in the clinic as every day, 16.50% ($n = 21$) every other day, 25.20% ($n = 32$) once a week, 9.40% ($n = 12$) once every 2 weeks, and 11.80% ($n = 15$) once a month. A majority, 83.50% ($n = 106$) of the participants worked voluntarily in the intensive care unit. While 19.70% ($n = 25$) of the nurses had COVID-19 and did not experience COVID-19 anxiety, 80.30% ($n = 102$) did not have COVID-19 and were concerned about having COVID-19.

There is a difference in attitudes toward end-of-life care between women (3.45 ± 0.52) and men (3.03 ± 0.69) ($p: .001$). There was no difference between other variables in terms of attitude toward end-of-life care.

In terms of approach to end-of-life care, there was a difference according to the units where the nurses worked ($p: .041$). This difference was between those working in the internal ICU (2.64 ± 0.83) and those working in the surgical ICU (3.03 ± 0.87), and between those working in the internal ICU (2.64 ± 0.83) and the pediatric ICU (3.02 ± 1.05). The score for approach to end-of-life care is lower for those working in internal ICU than those working in other ICUs. There was no difference between other variables in terms of approach to end-of-life care. In addition, there was no statistical relationship between the variables in terms of the COVID-19 anxiety scale.

A difference was found between women (4.13 ± 0.61) and men (4.13 ± 0.61) in terms of dying with dignity principles ($p: .008$). Women had higher scores than men. Also, dying with dignity principle mean scores differed statistically according to the marital status of the nurses ($p = .002$). The scores of married participants (4.17 ± 0.69) were higher than that of single participants (3.79 ± 0.75). In terms of dying with dignity principles, a statistical difference was found between the frequency of encountering a patient in the process of dying in the clinic ($p: .028$). This difference was found between the participants (4.20 ± 0.68) who faced the death process every day and those (3.64 ± 0.82) faced it once a week. A statistical difference was found among nurses in terms of COVID-19 anxiety and dying with dignity (0.020). The mean score of those who are afraid of COVID-19 (4.06 ± 0.7) is higher than those who are not (3.66 ± 0.83) (Table 1).

The relationship between dying with dignity scale and other scales is shown in Table 2.

As the dying with dignity scores increased, a significant correlation was found between the attitude toward end-of-life care ($r = 0.346$, $p = 0.0001$) and approach to end-of-life care ($r = 0.291$, $p = .001$). No relationship was found between dying with dignity and the COVID-19 anxiety scale ($p = .845$).

In our study, the mean score of the dying with dignity scale was 3.98 ± 0.74 , the mean score of the nurses' attitude and behavior toward end-of-life care scale was 3.03 ± 0.75 , and the mean score of the COVID-19 anxiety scale was 1.43 ± 0.71 .

Discussion

While participants in our study in general supported the principles of dying with dignity, their attitudes and approach to end-of-life care were at a good level. In addition, their COVID-19 anxiety was at a low level. In studies conducted with health professionals working in intensive care units, the level of adopting the principles of dying with dignity was found above the average (Aslan & Dundar, 2020; Cerit et al., 2021; Köse et al., 2019). In a study by Rostami et al. (2019), the majority of intensive care nurses (65.70%) had a moderate perception of futile care, and most (98.90%) had desired care behaviors in patient care during the last stages of life (Rostami et al., 2019).

Table 1. Comparison of the Demographic Characteristics of the Participants and Scale Scores (n = 144).

	% (n)	Attitude toward End-of-Life Care			Approach to End-of-Life Care			COVID-19 Anxiety			Dying with Dignity		
		$\mu \pm SD$	P		$\mu \pm SD$	P		$\mu \pm SD$	P		$\mu \pm SD$	P	
Gender													
Female	%63.8 (n = 81)	3.45 ± 0.52	0.001*		2.87 ± 0.88	0.168		1.46 ± 0.75	0.318		4.13 ± 0.61	0.008*	
Male	%36.2 (n = 46)	3.03 ± 0.69			2.65 ± 0.89			1.37 ± 0.63			4.13 ± 0.61		
Marital status													
Married	%50.4 (n = 64)	3.39 ± 0.54	0.276		2.76 ± 0.91	0.648		1.38 ± 0.64	0.733		4.17 ± 0.69	0.002*	
Single	%49.6 (n = 63)	3.21 ± 0.69			2.82 ± 0.86			1.48 ± 0.77			3.79 ± 0.75		
Unit worked in													
Internal ICU	%62.2 (n = 79)	3.24 ± 0.64	0.324		2.64 ± 0.83*	0.041*		1.51 ± 0.78	0.191		3.92 ± 0.83	0.625	
Surgical ICU	%26.8 (n = 34)	3.33 ± 0.51			3.03 ± 0.87**			1.24 ± 0.45			4.02 ± 0.54		
Pediatric ICU	%11 (n = 14)	3.55 ± 0.71			3.02 ± 1.05**			1.48 ± 0.74			4.21 ± 0.59		
Frequency of encountering a patient in the process of dying in the clinic													
Every day	%37 (n = 47)	3.38 ± 0.53	3.376		2.79 ± 0.82	0.531		1.41 ± 0.7	0.933		4.20 ± 0.68*	0.028*	
Every 2 days	%16.5 (n = 21)	3.27 ± 0.79			3.02 ± 0.97			1.51 ± 0.87			3.91 ± 0.79		
Once a week	%25.2 (n = 32)	3.34 ± 0.66			2.69 ± 1.02			1.5 ± 0.80			3.64 ± 0.82*		
Once every 2 weeks	%9.4 (n = 12)	3.32 ± 0.46			2.98 ± 0.62			1.36 ± 0.49			4.13 ± 0.58		
Once a month	%11.8 (n = 15)	3 ± 0.65			2.52 ± 0.79			1.32 ± 0.44			4 ± 0.57		
No	%80.3 (n = 102)	3.31 ± 0.6			2.75 ± 0.86			1.41 ± 0.65			3.99 ± 0.73		
Anxiety about experiencing COVID-19													
Yes	%80.3 (n = 102)	3.37 ± 0.55	0.054		2.78 ± 0.91	0.796		1.41 ± 0.68	0.738		4.06 ± 0.7	0.020*	
No	%19.7 (n = 25)	3 ± 0.82			2.82 ± 0.78			1.52 ± 0.84			3.66 ± 0.83		

Note. ICU = intensive care unit

*p < 0.05 statistical significance

Table 2. Relationship Between the Dying with Dignity Scale and Approach to End-of-Life Care and COVID-19 Anxiety Scales.

	Dying with Dignity (3.98 ± 0.74)		
	$\mu \pm SD$	<i>r</i>	<i>p</i>
Attitude toward end-of-life care	3.30 ± 0.62	0.346*	.0001*
Approaches to end-of-life care	2.79 ± 0.88	0.291*	.001*
COVID-19 anxiety	1.43 ± 0.71	−0.018	.845

In our study, intensive care nurses adopted the protection of dignity and privacy the most among the principles of dying with dignity. In a study by [Pasli Gurdogan et al. \(2017\)](#), participants' average scores on the principles of dying with dignity were at a good level, and they prioritized protecting dignity and privacy. Preserving the dignity and privacy of the individual during the dying process is an important component of dying with dignity principles. As an indicator of the importance given to human dignity in general, nurses respect the dignity and privacy of the dying patient. In a study, intensive care nurses stated that the actions to increase dignity in death in the end-of-life care are to fulfill patient and family wishes and protect privacy ([Becker et al., 2017](#)). The results of our study are similar to the previous studies.

The participants in our study stated that it is important to be with the dying patient. More than half of the nurses supported the definition of end-of-life care as “focusing on the needs of both the patient and the patient’s family.” The most adopted principles among the principles of dying with dignity in this study are wanting to have loved ones and pain management. In one study, Thai nurses emphasized the importance of holistic care and stated that good death includes awareness and acceptance of death, being prepared for death without suffering, being with loved ones, respect for dignity, being able to perform spiritual and religious practices ([Chaiyasit et al., 2020](#)). It has been stated in different studies that as an advocate of good death in end-of-life care, the nurse has the responsibility of providing symptom control, fulfilling the wishes of the patient, maintaining hope, and helping the family to accept the process ([Becker et al., 2017](#); [De Brasi et al., 2021](#); [Puente-Fernández et al., 2020](#)). Health professionals are often the sources of hope for the patient at the end of life. Health professionals should not exclude patients and their advocates in decisions regarding the end of life but should inform and include them in the process ([Sørensen & Andersen, 2019](#)).

In our study, the nurses stated that in end-of-life care, they mostly talk to the patient’s family about their previous life, try to provide a calm environment for the patient for a peaceful death, and adopt the approaches to ensure that the patient and the family are together in this process. It is important to focus on family at the end of life and that they supported for their responsibilities to fulfill the last wishes of terminally ill patients, to participate in care decisions, and to manage the post-mortem process ([Keeley, 2017](#)). [Gerber et al. \(2020\)](#) stated that in end-of-life care, family members of especially elderly patients are an important mediator between patients and healthcare professionals, and it

is important that family members are decision-makers on behalf of the patient in rapidly changing health conditions (Gerber *et al.*, 2020). Communication at the end of life is difficult, but critical for terminally ill patients, family members, and healthcare professionals for a “good death” (Keeley, 2017).

In our study, more than half of the nurses hesitated to talk to the family about what might happen to the patient during the death process. People’s lack of experience in the end-of-life process causes communication difficulties in this regard (Keeley, 2017) and causes them to avoid talking about the death process with their family (Puentes-Fernández *et al.*, 2020). Therefore, death is a difficult process to talk about. In the study conducted with patients, patient relatives and nurses, more than half of the patients and their relatives stated that they did not find it appropriate to talk about the death process with the person approaching death, and more than three quarters of the nurses stated that it should be talked about (Menekli *et al.*, 2021). Bergeholtz *et al.*, (2020) emphasized that personal and cultural characteristics are important in talking about end-of-life care and process, there are no certain standards in talking about end-of-life care, and communication is shaped according to the needs and expectations of the patient (Bergeholtz *et al.*, (2020). Talking about death with a dying patient can be thought of as an indication of the end of hope, and acceptance of nonexistence. Not knowing what people will encounter at the end of life, and not being able to share/know experiences about death and the process after, cause avoidance of communication on this subject.

In this study, the mean score of adopting dying with dignity principles and approach to end-of-life care was found to be low in nurses working in internal intensive care units and highest in those working in pediatric intensive care units. Comparable results were found in a study conducted with health professionals (Köse *et al.*, 2019). Contrary to the results of the study, nurses working in internal intensive care units were found to have higher levels of adopting the principles of dying with dignity (Aslan & Dundar, 2020). In another study, nurses working in the palliative care unit had good mortality attitudes (Menekli *et al.*, 2021). In a different study, health professionals working in the palliative care service adopted the principles of dying with dignity at a higher level than those working in intensive care units (Yıldız *et al.*, 2021). The worsening of the clinical condition in long-term hospitalizations, the communication and interaction process established with the patient and the family cause moral distress in nurses (De Brasi *et al.*, 2021). These differences may be due to individual experiences and perspectives on death.

Attitudes and approaches to end-of-life care, as well as attitudes to dying with dignity principles were not affected by COVID-19 anxiety in this study. However, the level of adopting the principles of dying with dignity was higher in nurses with COVID-19 anxiety, and a significant relationship was found between the state of experiencing illness anxiety and the attitude toward dying with dignity. In a different study, a significant relationship was found between death anxiety and the perceived threat of COVID-19 (Kavaklı *et al.*, 2020). Perceptions of good death may differ due to differences in individual perception, experience, belief, and socio-cultural context.

Also, the meaning of a good death differs based on the patient's views, their families, and health care providers (Chaiyasit et al., 2020). Nurses who have had COVID-19 attach more importance to the end-of-life care because they have high COVID-19 anxiety and know the course of the disease symptoms.

There was a significant difference between attitudes toward dying with dignity principles and attitudes toward end-of-life care in terms of genders, where the average score of women was higher. Similar to our study, women's average scores on the principles of death were found to be higher (Paslı Gürdoğan et al., 2017). In studies conducted using the same scale, there was no statistically significant difference between gender and the mean score of dying with dignity principles, and that the average score of female nurses regarding the principles of dying with dignity was higher (Aslan & Dundar, 2020; Yıldız et al., 2021). It can be said that women's attitudes toward death and end-of-life care may be at a better level than men, due to the gender difference and the fact that women can express their feelings clearly due to their sensitive psyche.

In this study, there was a significant relationship between marital status and attitude scores toward dying with dignity. Married participants were more likely to adopt the principles of dying with dignity. In a study conducted with palliative care nurses, married nurses had higher mean scores on the good death scale (Menekli et al., 2021). In the study conducted with health professionals, no significant relationship was found between marital status and adopting dying with dignity principles (Köse et al., 2019). In addition to individual characteristics, support of spouse and children of married nurses while encountering patients' death is important.

A significant relationship was found between the frequency of encountering a patient who is in the process of dying in the clinic and the mean score of approaching the principles of dying with dignity. Nurses who encountered patients who were in the process of dying were more likely to adopt dying with dignity principles. In order to ensure a good death, Thai nurses have emphasized the importance of experience in providing care and adopting holistic care practices such as physical, psychological, social, and spiritual care (Chaiyasit et al., 2020). Hold (2017) stated that experienced nurses take their professional values, individual experiences, and institutional policies as a guide in solving ethical problems related to end-of-life care and good death. Nurses have a profound impact on the attitudes of patients and their families in the end-of-life care process and have a key role in patient care and end-of-life decision-making. It is necessary to provide support and counseling services to patients and their families on ethical issues around futile treatment by healthcare members (Rostami & Jafari, 2016). In the study by Paslı Gürdoğan et al. (2017), as the professional experience of nurses increased, they adopted the principles of dying with dignity more. In a study by Yıldız et al. (2021), the dying with dignity attitude scale scores of those who encountered death in the clinic were found to be lower. These differences may be due to individual differences in attitudes toward death.

Conclusion and Recommendations

The difficulties experienced in health services during the pandemic and the course of the disease caused many people to die and left health professionals helpless. In our study, the participants' attitudes toward the principles of dying with dignity were positive, their attitudes and approach to end-of-life care were at a good level, and their COVID-19 anxiety was at a low level. As the COVID-19 pandemic has been going on for nearly 2 years and treatment and prevention options are on the agenda more clearly, anxiety is decreasing. Intensive care nurses care most about patient dignity, protection of privacy, pain, and symptom control. With the increase of nurses' awareness of dying with dignity, communication with dying patients and their families will improve, and they will be able to talk more comfortably with patients and their relatives about the process. In this context, it is recommended to plan trainings and scientific activities for health professionals to strengthen communication in end-of-life care.

Limitation

This study is limited to the nurses working in the intensive care unit of only one university hospital. The ongoing pandemic and the intensive work of nurses during the data collection period led to limitations in the research.

Author Contributions

Rana CAN ÖZDEMİR and Meryem Türkan IŞIK Study conception and design, Data analysis and interpretation, Drafting of the article, Critical revision of the article. Havva DOĞAN, Data collection, Drafting of the article, Critical revision of the article. and Sema ERDEN ERTÜRK Data analysis and interpretation, Drafting of the article. Critical revision of the article.

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Ethical Approval

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