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Threats to the dignity of COVID-19 patients: A qualititative study

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Abstract

Background: Dignity is a fundamental concept that has been threatened by the COVID-19 pandemic. Several factors threaten the dignity of COVID-19 patients, whether in palliative care departments, medical or surgery wards, intensive care units, or long-term care facilities. This threat is exacerbated by the increasing number of affected patients, the high transmission of the virus and problems such as limited resources, shortage of workforce, and ineffective communication. Recognizing the threats and challenges that currently affect the patients' dignity and managing them can help maintain the patients' dignity and increase their satisfaction.
Research objective: This study seeks to explain the threats to the dignity of hospitalized COVID-19 patients.
Research design: This qualitative study was conducted using conventional content analysis. Data were collected through in-depth, semi-structured, face-to-face interviews with 21 COVID-19 patients with maximum variation. Data were analyzed using Graneheim and Lundman's conventional content analysis and encoded with MAXQDA-10 software. The participants had already recovered from COVID-19 when the interviews were held.
Ethical considerations: The study protocol was approved by the Research Ethics Committee of medical universities in northwestern Iran (IR.UMSU.REC.1399.345). Ethical principles were observed during the study.
Findings: The analysis of the interviews revealed three main categories and 11 subcategories for the threats to the dignity of COVID-19 patients. The main categories included facing imposed conditions (five subcategories), facing unprofessional performance (four subcategories), and ineffective communication (two subcategories).
Conclusion: The findings of the present study can help health officials and policymakers in taking positive steps to maintain patients' dignity by designing and implementing beneficial programs.

Keywords

COVID-19, recovered patients, dignity, content analysis, nurse

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Introduction

Respect for human dignity is an ethical principle and professional duty of medical staff and is actually a sort of respect for individuals' and populations' unique intrinsic value.[1] Dignity can be considered in both absolute and relative forms. Absolute dignity is respect for individuals regardless of their positions and responsibilities that is never threatened or destroyed. Relative dignity depends on education, social class, religion, and culture, which can easily jeopardize dignity.[2] Impaired health and illness are major factors that severely threaten individuals' dignity and make them prone to loss of dignity; in fact, patients feel the threat to their dignity from the moment they get admitted and hospitalized until they are discharged.[3] As an emerging disease, COVID-19 has created difficult conditions all over the world and created many challenges for those infected. The health system, especially the Iranian health system, is facing new issues that are further exacerbated by the imposed sanctions. The current economic situation in Iran and the lack of personal protective equipment, shortage of workforce and limited facilities in Iran and some other countries along with the particular characteristics of the virus, such as rapid transmission, have made it difficult to maintain COVID-19 patients' dignity.

COVID-19 patients' initial contact with healthcare providers occurs by touch through latex layers, eye contact through goggles and plastic face shields. A recent systematic review reported that hospitalized patients isolated for medical reasons are more likely to experience depression, anxiety, anger, and loss of self-esteem.[4] Pandemic observations have shown that healthcare providers are forced to deliver what can only be called "poor care," where commitment to patient care must be weighed against commitment to self and family protection.[5,6] According to studies, the non-observance of human dignity is associated with adverse consequences such as fear, disbelief, shock and denial, anger, hatred, indifference, sadness, and frustration and ultimately has undeniable effects on individuals' health.[7–9] Also, disrespect for individuals' dignity leads to unnecessary tensions and causes a lot of physical and mental pressure for the person, which in turn can lead to circulatory disorders, high blood pressure, and cardiovascular diseases.[10] In contrast, maintaining patients' dignity reduces stress, increases trust and satisfaction, reduces the length of hospital stay, and improves treatment outcomes.[1]

Since this subject is well worthy of further research and given the existing conditions, the little information on the topic, the importance of providing quality care, the various psychological problems imposed by the disease on patients and their families, and the numerous challenges affecting different dimensions of these patients' life, gaining a deep understanding of the factors threatening patients' dignity can play an important role in improving the quality of care and maintaining their dignity. Therefore, the present study was carried out to explain the threats to the dignity of COVID-19 patients using content analysis. Effective interventions can be devised to maintain the patients' dignity after learning about the perceived threats to their dignity in hospitals.

Methodology

Study design

As the choice of method depends on the aim of the study, qualitative conventional content analysis was used for data collection and analysis in the present research. Content analysis deals with meanings, intentions, consequences and context. It can aid in understanding the meaning of communications,[11] discovering people's understanding of life phenomena, and interpreting the content of subjective data.[12] In conventional content analysis, categories are extracted directly from the text of the data.[13] This method was thus selected in this study to obtain new and rich datasets.

Participants and study setting

This study was performed on COVID-19 patients with a history of hospitalization in COVID-19 hospitals in northwestern Iran. Purposive sampling was used to select the participants, and sampling continued until data

saturation was reached. The first participant was a retired hospital administrative staff with a history of hospitalization in the same hospital for COVID-19, who was introduced by the nursing manager; two of the participants were introduced by some colleagues and nurses. Based on the data obtained from the interviews, the next participants were selected from the list of COVID-19 patients discharged from the internal medicine wards and ICUs of the select hospitals in northwestern Iran. Some participants were also introduced to the researcher by the previous participants. For each interview, the researcher first called the participant and introduced himself and explained the purpose of the research, and then determined the time and place of the interview based on the participant's wishes and willingness to take part in the project. The inclusion criteria consisted of age over 18 years, a history of hospitalization for over 48 h in internal medicine wards or ICUs with a diagnosis of COVID-19, no psychological and physical disorders, such as PTSD, depression and anxiety, shortness of breath, dry cough, or Chronic Fatigue Syndrome based on a specialist's confirmation, ability to transfer their experiences, and willingness to participate in the study. The exclusion criterion was the participant's decision to withdraw from the study at any time during the research. The patients were selected with maximum diversity in terms of demographic characteristics such as age, sex, marital status, level of education, and socioeconomic status.

Participants

A total of 21 patients with COVID-19, including 10 females and 11 males, who had recovered from the disease participated in the study. They were between 22 and 80 years old and their mean age was 49.95 years. The number of hospitalization days was 2–40 days and its mean was 11.95 (Table1).

Data collection

Data were collected through 21 semi-structured in-depth interviews held from March to September 2021. Purposeful sampling continued until data saturation was achieved. Face-to-face interviews were conducted in a private and quiet environment with participants' consent and willingness. The interviews began with a general question: "Please talk about when you were infected with COVID-19." Depending on participants' answers, the following questions were then asked: "Which factors negatively affected your dignity and undermined it during your hospitalization?" and "How did you feel after your dignity was compromised?" Exploratory questions such as "What exactly do you mean," "Please elaborate," and "Please give an example" were used to get the in-depth data and for clarification and to ensure in-depth interviews. Each interview session lasted 45–60 min. All the sessions were recorded using an Android smartphone and immediately transcribed verbatim. Draft manuscripts of the interviews were given back to the participants to be reviewed and their ambiguities were clarified. In support of the data analysis process, the interviewer's observations and perceptions about the participants were also recorded (Table 2).

Data analysis

Simultaneously with data collection, data analysis was also performed using Graneheim and Lundman's qualitative content analysis and constant comparison.[12] At the end of each interview session, the audio file and researcher's notes were carefully transcribed by two of the authors (FN and SHY). The recorded and transcribed interviews were read several times to ensure a deep and general understanding of their content. The initial codes were extracted during the constant comparison step and then classified according to their similarities and differences. Data were analyzed using MAXQDA software (version 10 R 160410; Udo Kuckartz, Berlin, Germany) by three of the authors (FN, LA, and MH).

Table 1. Participants' demographic characteristics.

Participant no	Gender	Age (year)	Number of hospitalization days	Inpatient ward
P1	Male	47	25	ICU
P2	Male	35	4	Internal medicine
P3	Male	73	11	Internal medicine
P4	Male	42	5	Internal medicine
P5	Male	50	15	Internal medicine
P6	Male	80	15	Internal medicine
P7	Female	42	5	Internal medicine
P8	Female	40	5	Internal medicine
P9	Female	49	8	Internal medicine
P10	Female	40	5	Internal medicine
P11	Female	75	15	ICU
P12	Male	80	5	Internal medicine
P13	Female	75	13	Internal medicine
P14	Male	40	2	Internal medicine
P15	Female	22	7	Internal medicine
P16	Female	47	5	Internal medicine
P17	Female	55	25	Internal medicine
P18	Female	48	40	Internal medicine
P19	Male	30	14	Internal medicine
P20	Male	51	7	Internal medicine
P21	Male	28	20	Internal medicine

Table 2. A sample of the questions used in the interviews.

Questions:
1. Please talk about when you were infected with COVID-19.
2. Which factors negatively affected your dignity and undermined it during your hospitalization?
3. How did you feel after your dignity was compromised?
4. What problems did you face during your illness and hospitalization?
5. Tell us about your most unpleasant experiences.
6. Tell us about your quarantine experiences.
7. Tell us about your experiences after recovering from COVID-19.

Trustworthiness of the study

To ensure the trustworthiness of the findings, we used the four criteria such as credibility, dependability, conformability, and transferability.[14] Member-checking with participants during the process of data collection and analysis, and prolonged engagement with the data were used to ensure credibility. Moreover, employing the peer-checking techniques for supported credibility of the findings for dependability, the raw data, codes, and subcategories were saved for audit purposes, and all procedures of the study and details were noted and recorded. To establish conformability, the research team's collective opinions were included in all stages of data analyzing. The sampling with maximum diversity was used to enhance the transferability of findings.

Ethical considerations

This study was approved by the Research Ethics Committee of Urmia University of Medical Sciences located in northwestern Iran (IR.UMSU.REC.1399.345). The participants were briefed on the study objectives and ensured about the confidentiality of their information (e.g., names and personal issues and recorded interviews). They were also reassured that they could withdraw from the study at any stage. Informed written consent was obtained from all the participants.

Results

Based on the data analysis, three main categories and 11 subcategories were identified. The main categories included facing imposed conditions, facing unprofessional performance, and ineffective communication. These categories are explained along with their subcategories in the following section (Table 3).

Category 1: Facing imposed conditions

One of the most important experiences of all the participants was facing imposed conditions. The main factors contributing to this category included an environment full of shortcomings, shortage of workforce, violation of patients' privacy and independence, mandatory presence of patient's family, financial insecurity, and unpredictable economic conditions.

- An environment full of shortcomings

All the participants complained about the lack of liquid soap, sufficient bedding and pillows, change of bedding, cleaning services for the COVID-19 rooms, medicines and proper meals, and shower facilities. They said that the failure to meet these basic and essential needs disturbs the patients and threatens their dignity.

One of the patients said:

"Since the time I was admitted until now, the bedding has not been changed; the hospital doesn't have a shower. How will you feel if you can't take a shower for a whole month? I really can't stand it; I'm so upset. They should put themselves in our shoes; would they stand it?" (P3, Male, 51 years).

Table 3. Categories and subcategories.

	Categories	Subcategories
Threats to patients' dignity	Facing imposed conditions	• An environment full of shortcomings • Shortage of workforce • Violation of the patients' privacy and independence • Mandatory presence of patients' family • Financial insecurity and unpredictable economic conditions
	Facing unprofessional performance	• Feeling neglected and ignored • Feeling disrespected • Patients facing staff's retaliatory actions • Nontransparent treatment process and consequences
	Ineffective communication	• Ineffective communication due to the disease communicability (avoidance) • Ineffective communication due to the staff's use of personal protective equipment

- Shortage of workforce

The experiences of most patients showed that COVID-19 patients need more care than other patients, especially when the whole family is infected; however, due to the shortage of workforce, they have to wait a long time and this negative experience of long waiting reduces their dignity.

"There were so many patients. Sometimes the nurses didn't come when I rang the bell. Sometimes they were tired and came late, or when they gave me medicines, they would quickly get angry and I got upset too" (P9, Female, 75 years).

- Violation of patients' privacy and independence

Based on patients' experiences, because hospitals did not have empty beds, patients did not have the right to choose their physician, ward, or hospital, and their independence was thus violated. Another negative experience was forced hospitalization in mixed-gender wards and not receiving care from same-gender personnel, which is often considered dreadful in the Iranian culture and tarnished the patients' dignity. A female participant said:

"I had defecated my pants and needed to go to the restroom and change my clothes and bedding. After a long wait and crying, they sent a male patient care assistance and he grabbed my hand and helped me and I was very upset, and I wished I had died but didn't experience such conditions" (P5,Female, 48 years).

- Compulsory presence of patients' family

Based on the experiences of the participants and their family in those difficult COVID-19 conditions, where the probability of infection was very high, hospitals had to formulate policies and prevent the presence of family members, and visit hours had to be limited to behind closed windows. Meanwhile, due to the shortage of workforce and fear of getting infected, the hospital staff forced the patients to bring their family and friends as their personal caregivers, which means that they did not value the patients and their family and did not care about their health and basically ignored their human dignity. One participant said:

"Forcing us to have our family as caregivers got my brother infected, and I feel guilty for this and so sad that I harmed my brother" (P7, Male, 47 years).

- Financial insecurity and unpredictable economic conditions

Many participants expected their treatment costs to be free, as was earlier promised by the authorities; however, they said that they were charged high fees for their treatment, and some of them could hardly afford them and some were also worried about their household income and family and had no savings. They worried about their family for these reasons and felt worthless as they could not do anything about it, which also damaged their dignity.

"I am self-employed and now that I'm hospitalized and don't work, I don't really know if I should be worried about my poor physical condition or my family's economy. On the other hand, COVID-19 medicines cost a lot; we paid 3 million Tomans for each injection and spent all our savings, and there's no one to come and understand our situation. Not a support organization nor anything else; they don't ask themselves how people like us and our families are supposed to make a living in such conditions with such great expenses. And that's why I feel ashamed in front of my family, and because I can't do anything, I get super annoyed and feel worthless" (P12, Male, 50 years).

Category 2: Facing unprofessional performance

The participants said that they had higher expectations of healthcare providers due to their high level of education and social status and thought that they should not treat us the way ordinary people in the community did, as they had more knowledge about the disease and had to understand the difficulty of their situation. According to the patients, the sense of being neglected, ignored and disrespected, having to face the staff's retaliatory behaviors, and falling victim to the nontransparent process and consequences of the treatments were factors reflecting the unprofessional performance of some of the staff.

- Feeling neglected and ignored

The participants complained of the staff's negligence in performing their duties, poor accountability and training, and carelessness in responding to the patients' complaints. One participant said:

"I had to ask three or four times for them to remove my IV drip, and then, instead of coming themselves, they would send a patient care assistance. Can the patient care assistance insert or adjust the IV drip really?" (P6, Female, 22 years).

Another participant stated:

"When they gave me medicines, I asked what the medicine was for, and they said, "It's a Covid medicine. Just take it. What else can I tell you." They didn't give any explanations to me. Sometimes I insisted and got the name of the medication and looked it up online" (P2, Female, 40 years).

- Feeling disrespected

Participants' experiences revealed that disrespect manifested through stigmatizing behaviors is a challenging issue that leads to negative self-perceptions and reduced unity of treatments and medical adherence. The participants had a bad feeling about themselves and felt stigmatized for their illness due to other people's (including the medical staff's) poor and avoidant behaviors. One participant said:

"We were treated like a virus and were called by our bed numbers instead of our names. For example, they told the chef, 'Give diabetic food to Covid patient number 1!" (P12, Male, 50 years).

- Facing staff's retaliatory behaviors

Participants' experiences showed that, contrary to what they expected of professional medical staff, they witnessed completely revengeful behaviors from the staff far from common sense, which tarnished their dignity as patients. A participant said:

"Once when I had just come out of the ICU and they have given me a laxative, I could not control myself and defecated in the bed. I asked them to change the sheets. They left me in that condition for one whole hour and said they had something else to take care of. I felt like I was being punished for defecating in the bed. I asked for a blanket, they responded, "Why did you stain it?" and didn't give me nothing. It was very cold. I slept in the cold until morning and was really upset and felt they did not value me. This behavior actually made my lung involvement worse" (P5, Female, 48 years).

- Nontransparent process and consequences of treatments

The participants showed that their worst experience was being kept in the dark about the disease by the treatment staff and the nontransparent process of the treatment. They stated that it was their absolute right to

be informed about their medical situation or to receive correct information and know what medicines they are receiving. This confusion and ambiguity damaged the patients' dignity.

"Every day when they visited me, I asked if I was getting any better. The doctor did not answer me at all, and I was always stressed that I had gotten worse and they didn't tell me. Or I asked if the drugs had been at all effective. They said "They will be." I asked about my condition, but they didn't say what percentage of my lungs was involved" (P6, Female, 22 years).

Category 3: Ineffective communication

Even though medical staff are also obliged to protect themselves in such situation, which means that communication becomes difficult, it is still possible for the physicians, nurses, and other healthcare staff to establish verbal and non-verbal communication with the patients and convey their feelings, attitudes, and necessary information to them so as to reduce their concerns. The participants suggested the communicability of the disease, which led to the staff's avoidance behaviors, and also the staff's use of personal protective equipment as inhibitors of effective communication between them.

Ineffective communication due to the disease communicability (avoidance). Participants' experiences revealed that they followed all the health protocols, but the staff still did not want to talk to them due to their fear of getting infected through the droplets released by the patient breathing and talking, and they therefore did not allow the patients to talk, even though they were armed with personal protective equipment.

One participant said:

"The staff avoided us and behaved like robots toward us; there was nothing of empathy and compassion; they didn't want to get close to me at all; even when they entered the room and I wanted to move, they would say, 'Stay there; don't come near us!' It didn't feel good at all" (P14, Male, 35 years).

Ineffective communication due to the staff's use of personal protective equipment. Most of the participants discussed the importance of effective communication between physicians and nurses and patients. In addition to being unhappy about the non-existence of non-verbal communication due to PPE acting as a barrier, most patients also complained about the lack of verbal communication. Some participants did not know their nurse or doctor at all.

A participant stated:

"The physician came in covering himself up like a spaceman, and we didn't even know who he was. He didn't talk to us at all. He would say, "Stay hospitalized today to see what happens." There were no examinations, no words. He didn't even answer our questions and left the room quickly" (P2, Female, 40 years).

Discussion

According to the participants, the perceived threats to their dignity could be divided into the three categories of facing imposed conditions, facing unprofessional performance, and ineffective communication; they stated that their crushed dignity gave them a sense of worthlessness and made them discouraged during these difficult times.

Facing imposed conditions

An environment full of shortcomings, shortage of workforce, violation of patients' privacy and independence, the mandatory presence of patient's family, financial insecurity, and unpredictable economic conditions were factors that crushed the patients' dignity. It should be noted that Iran was not prepared to deal with this

epidemic crisis due to the US-imposed sanctions, the unavailability of protective equipment, insufficient ICU beds, lack of monitoring devices, shortage of specialists and poor primary healthcare services offered in cities, heavy workloads, lack of a known treatment for the disease, and the staff getting infected themselves and the resultant reduced active workforce in hospitals.[15] According to studies, other countries had the same problems and suffered from limited resources such as personnel, hospital beds, and equipment, which increased their vulnerability as well[16,17] and threatened their patients' dignity. In the present study, the participants were deprived of the right to choose their own physician and hospital due to the lack of resources. Other studies have also reported the complete deprivation of privacy and the consequent violation of autonomy and dignity due to the lack of resources.[18,19]

The participants in the present study also expressed unhappiness with how it was mandatory for their family to be by their side and take care of them, as they feared transmitting infection to them. According to various studies, different policies have been adopted and implemented regarding families visiting their COVID-19 patients and participating in caregiving, and some hospitals have found these visits beneficial of the health protocols and instructions are carefully obeyed, especially in the cases of older patients, pregnant women, and those with mental health problems and delusions.[20,21] Some studies, however, view these visits as a threat to the patients' life and a cause for the further spread of infection to the staff and other family members and therefore disapprove of hospital visits for COVID-19 patients.[16,22]

In the present study, some participants were concerned about their poverty, high costs of treatment, lack of insurance coverage, and the possibility of losing their job and being unable to meet their families' needs, which severely undermined their dignity. In other studies, patients expressed financial issues as one of their main concerns, and some participants were automatically fired from work due to illness and some even needed a few months of rest before going back to work even after making full recovery. They suggested that the government should take measures to cover the costs of treatment of this disease and provide for the patients' basic needs when they are hospitalized.[18,23]

Facing unprofessional performance

From participants' point of view, feeling neglected, ignored and disrespected, facing staff's retaliatory behaviors, and the nontransparent process and consequences of treatments are factors that damage individuals' dignity. Regarding feeling neglected by the staff and their aggressive behaviors, it should be noted that the prevention of violence and conflicts in epidemics is much more complex. The reason is that, during epidemics, the general public, including the medical staff as well as patients and their families, experience tremendous pressure, and all staff, especially those in intensive care units, suffer from severe lack of sleep, anxiety, depression, and stress symptoms.[24,25] All these issues affect the behavior of the medical staff toward the patients, causing violence and tension and damaging the patients' dignity. Furthermore, patients are also in a bad mood mentally due to the lack of resources, long waiting times, and the disparity between their expectations and the provided services.[26] At such times, mental health professionals and online mental health services can prove very helpful.

In a study by Hsiao et al., the participants reported stigmatization and disrespect as part of their negative experiences.[27] In another study, the participants experienced problems in their interpersonal relationships because of others' negative views on the ill, as people equated the patients with the disease, calling them names such as "virus" and "virus spreader." Some participants were hurt by the COVID-19 jokes that were inadvertently spread around them. They felt betrayed because their friends avoided them and talked about them behind their back.[18]

Regarding the nontransparent process and consequences of treatments, although the whole world has faced ambiguities in relation to the emerging SARS-CoV-2 virus, in most clinical and hospital settings, we have witnessed patients being deprived of the right to know about the severity of their illness, pulmonary

involvement, name of prescribed medicines, blood oxygen levels, etc. Even if they complain about these issues, they receive harsh responses. One of the reasons for this sort of treatment is that patients might grow more concerned if they learn of their actual disease severity, even though most patients today are aware of their rights and are very eager to know more about their medical condition and to participate in their treatment and care decisions alongside their physician and nurse.

Ineffective communication

Similar to Iran, other countries have also had to deal with the problem of ineffective communication due to the patients' conditions (respiratory failure, use of ventilators, use of oxygen delivery devices such as oxygen masks, severe delusions due to the severity of the disease, etc.), patients' lack of trust in healthcare systems, lack of attention to the patients' non-verbal feelings, and lack of knowledge about tools and devices to facilitate communication, especially in older adults, thus leading to many challenges for the patients and their families by causing isolation, fear, and suffering.[28,29] Besides, there are no resources to provide guidance and assistance to non-physician service providers regarding communication with the families and telecommunication strategies to promote family interactions,[30] which make clear and fair communication more difficult and even more important. For even the most skilled practitioners of humanitarian communication, the pressure of reacting quickly to public health crises can undermine communication performance. This complexity occurs in the context of collective fear, which affects not only communication but also its evaluation.[29] Therefore, innovative strategies are needed to ensure that high-quality communication occurs despite the limitations on visiting patients during a pandemic.[31]

Based on the experiences of the participants in this study, almost everyone experienced some degree of harm to their dignity and its negligence. In general, participants' complaints about the threat to their dignity and efforts to protect it had proven futile and had led to further threats to their dignity. Since nurses are the largest group of care providers in hospitals, they can play an important role in maintaining patients' dignity because they spend a lot of time with patients and provide the most care to patients, and are deeply in contact with their feelings and concerns. However, since training workshops were not held in the hospitals under our study to inform them and increase their knowledge about the nature of the disease and how to communicate effectively during this pandemic period, and that most nurses working in the studied hospitals did not have the necessary skills in using computer and search methods and were not fluent in English, they could not use evidence-based nursing in the care of patients with the emerging disease of COVID-19 and had unprofessional performance. Therefore, nurses, as patients' rights defenders, can increase their skills and participate in the necessary training workshops around the world to have a professional performance in maintaining patients' dignity.

Limitations

The findings of patients participating in this study who had a history of hospitalization in northwestern Iran cannot be generalized to the findings of patients admitted to different parts of Iran and the world, because hospital equipment, facilities, and quarantine and visitation rules are different in other communities due to the different prevalence of COVID-19. As expectations of health care vary in different cultural, political, economic, and social conditions, so to increase the generalizability of results, it is recommended to conduct studies in this area in other communities to increase knowledge of various aspects of threats to the dignity of patients with COVID-19.

Conclusion

This study showed that according to patients' perspectives, there are gaps in maintaining patients' dignity; and "facing the imposed conditions," "facing the unprofessional performance of staff," and "ineffective

communication" are obstacles to achieving dignity. However, there is no systematic professional organization to assess the responsibility to protect and enhance patients' dignity in Iran. Given that many of these threats are controllable, identifying them will enable healthcare providers and health policymakers to take positive steps to maintain COVID-19 patients' dignity by training qualified nurses, holding the necessary training workshops, providing adequate insurance support for patients, supporting patients that have lost their jobs, and increasing hospital facilities.

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Author contributions

FN, LA, MH, and SY organized data collection and wrote the manuscript. FN and SY carried out the interviews. FN, LA, and MH contributed to the data analysis. All authors conceptualized, designed the study, read, and approved the final draft.

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Abbreviations

PTSD	Post-Traumatic Stress Syndrome
ICU	intensive care unit
PPE	personal protective equipment