Nurses' challenges, concerns and unfair requirements during the COVID-19 outbreak

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Abstract

Background: During disease outbreaks, nurses express concerns regarding the organizational and social support required to manage role conflicts.
Objectives: The study examined concerns, threats, and attitudes relating to care provision during the COVID-19 outbreak among nurses in Israel.
Design: A 53-item questionnaire was designed for this research, including four open-ended questions. The article used a qualitative research to analyze the responses to the open-ended questions and their association with responses to the close-ended ones.
Participants and research context: In all, 231 registered nurses and fourth-year nursing students throughout the whole country. The questionnaire was delivered in nursing Facebook and WhatsApp groups and through snowball sampling.
Ethical considerations: The research was pre-approved by the Ethics Committee at the researchers' university.
Results: Nurses mostly referred to personal risk, followed by dilemmas regarding care provision. On average, 38.6% of quotations stated that during the pandemic, nurses are not asked to perform unfair duties. Nurses discussed activities and requirements that impact their personal and familial safety, their relationship with employer, organization or the state, and their duty to providing care. Other than fear of contraction, respondents' most frequent themes of concerns were related to work condition and patients' interests, inter-collegiate relationships, and uncertainty and worries about the future. Respondents' ethical dilemmas mostly referred to clinical questions, providing care without adequate equipment or managerial support, and in conditions of uncertainty and increased risk.
Discussion: Nurses raise important issues concerning their relationships with employers and family members, and significant insights regarding the pandemic and their revised responsibilities and definition of work. They raise serious concerns regarding their rights at work and their standing for them.
Conclusions: Health managers should find ways to enhance the ethical climate and institutional support to enable a better work-life balance in times of pandemic and support nurses' working needs and labor rights.

Keywords

Clinical dilemmas, COVID-19, duty of care, family, qualitative research, risk, rights at work, work-life balance

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Introduction

The significant and rapid spread of Covid-19 around the globe has had an enormous effect on people's wellbeing, health, and economy. By 24 February 2021, there had been more than 111 million confirmed cases of COVID-19, in 223 countries or territories—including almost 2.5 million deaths.[1] When managing this dynamic and new pandemic, healthcare providers face the gravest and most complicated challenges and opportunities. Positioned at the forefront nurses fight the disease at their own personal risk of infection for themselves, their families, and others with whom they may come into contact.

The more widespread the pandemic, the more serious its implications, and in turn—the more intensified the required clinical care. As a result, nurses have to accommodate new protocols, work long shifts, and deal not only with patients but also with their remote family members.[2,3] Lack of medical resources and protective equipment for medical personnel,[4] combined with a shortage of nurses during pandemics, as a result of quarantine,[5] also make nursing care a difficult and challenging task.

As a result, nursing care in times of pandemics is extremely stressful and demanding[6,7] and is frequently associated with anxiety, depression and anger.[8,9] Such negative experiences may be related to reduced levels of resilience and burnout, and as such, may increase nurses' intentions to leave the profession.[10]

Nurses express various concerns during outbreaks of infectious diseases, with a focus on the organizational and social support that they require in order for them to manage role conflicts. For example, a study of 100 Canadian nurses following the SARS outbreak found that nurses fear they might infect their loved ones and feel guilty about that. However, if they choose not to work in such a situation, then they feel guilty toward their co-workers.[11]

Nurses also discuss the need for them to hire someone to take care of their child, elderly family member, or pet when they are required to stay at work. They also emphasize the need to find time for communication with their families during long shifts or quarantine.[11] Moreover, interviews with emergency nurses in Hong Kong following the Human Swine Influenza also show that nurses worry about contracting the disease and transmitting it to their family members. Many refer to excessive guidelines and rapidly changing regulations, increased workloads, and inadequate and personal protective equipment that is not user friendly.[12]

Yet despite these worries and concerns, surveys completed by healthcare providers, including nurses, show that most do not convey an actual intention to leave the profession, abandon their workplace, or refuse to care for sick or carrier patients in times of personal risk.[13–15] Such contrasting attitudes create conflict and tension among nurses when providing care during times of disasters, personal risks, or pandemics—and could harm their physical and mental wellbeing, and have clinical implications on the nurses and on the people they serve. Indeed, nurses' working environments, staff strength, leadership effectiveness, involvement in decision making, strain, and burnout and work-life problems—especially during a pandemic—affect the quality of care provided by nurses at the professional level.[16]

Israel has a modern market-based economy and a population of 9.3 million. It provides universal health coverage and is characterized by an efficient healthcare system.[17] Prior to lifting its third nationwide lockdown, the country experienced a major increase in infections, leading to significant morbidity.[18] More recently, it has administrated the highest rates per 100 population of the COVID-19 vaccine in the world,[19] with almost 50% of its all population having been vaccinated with at least one of the two required dose of the Pfizer-BioNTech vaccine. This exceptionally successful vaccine program has resulted in vaccine effectiveness against verified infections, symptomatic illnesses, hospitalization, and severe diseases.[20]

Providing healthcare services during the COVID-19 pandemic gives rise to serious ethical and organizational tension and dilemmas all over the world. Moreover, managing them within the organizational context is central to the job satisfaction and work motivation of nurses. As such, this study focuses on the organizational and ethical support provided to nurses during the COVID-19 pandemic and the effect of such support on ethical and motivational aspects of providing healthcare.

Research purposes

This research examines the following question: What concerns, threats, and attitudes do nurses in Israel have in relation to providing care during the COVID-19 outbreak? The research has two main purposes: (1) To explore nurses' ethical dilemmas and attitudes regarding care provision during COVID-19 and their concerns associated with such care on personal and organizational levels and (2) to examine whether and to what extent the nurses' perceived risks and motivation for working during the COVID-19 outbreak are associated with their attitudes regarding care provision during the pandemic.

Research design

The study applied a descriptive qualitative research.[21,22] It is based on four open-ended questions that were included in a 53-question questionnaire and the relationship between the responses to these questions and to additional closed-ended questions that were included in the same questionnaire. The open-ended questions were related to the respondents' descriptions of their work, how they perceive the pandemic, their fears and concerns, and the tasks and assignments that they have been asked to perform during the COVID-19 outbreak.

The complete questionnaire included the following sections: The first 19 items examined work-related and socio-demographic characteristics, having COVID-19 guidelines, and being in contact with someone who is considered high risk for COVID-19 virus. For the second part of the questionnaire, respondents rated the extent to which they agree with 18 statements concerning their confidence when caring for sick or carrier patients, ethical dilemmas relating to providing care during the pandemic, their compliance with guidelines on COVID-19, and the implications of care provision during the pandemic on their career decisions. Next, respondents were asked to rate their perception of risk for contracting the COVID-19 virus. In the fourth part of the questionnaire, participants were asked to rate nine items referring to a nurse's right to refuse to provide a patient with healthcare, ethical decision-making, and ethical climates. Finally, respondents were asked to rank motivational factors relating to working in the health system during the COVID-19—and their importance.

Of the 53 questions presented in total on the questionnaire, most were developed especially for this research, including the open-ended questions; 18 questions contained items that were taken from an existing and validated questionnaire.[23] Analysis of the full questionnaire, excluding the open-ended questions, has been published in a separate paper.[15]

Participants and research context

Following a pilot test of 15 nurses and revision of the draft questionnaire, a link to an online questionnaire was posted on one nursing WhatsApp group and on 18 various Facebook groups for nurses, which include members from the nursing community in different locations and organizations in Israel. This also led to a snowball sampling of registered nurses across the country and recruitment of fourth-year students (mostly from our university but not only) through snowball sampling. The link was posted twice in some groups.

While fourth-year nursing students are not authorized to provide care like registered nurses, they do practice generic skills and are exposed to the clinical setting in hospitals in preparation for their governmental exam which they take at the end of their fourth year. Although these students do not care for COVID-19 patients suffering from severe diseases that require ventilation, they may be responsible for medium-risk patients who are hospitalized in Internal Medicine Wards. In addition, all fourth year students who participated in the study received training on COVID-19 via an educational computer

program, as COVID-19 is a new disease that has yet to be included in the syllabus. Hence, it was important to survey their opinions as well.

Due to personal risk of contamination and strict guidelines limiting the entrance of non-patients into hospitals, online recruitment of participants was optimal means for allowing the rapid response of nurses throughout the country. To overcome ethical issues that are often associated with online surveys, such as confidence levels of the collected data and its quality for research purposes,[24] we only analyzed questionnaires that had been answered in full were included in the study. Moreover, the survey's internal consistency and reliability were calculated and measured to minimize, revise, or delete certain items from the analysis, if and when necessary. The study began on 13 April 2020—at the height of the COVID-19 outbreak in Israel—and ended on 9 May 2020, following a significant decrease in the number of newly diagnosed patients.

Analysis

The qualitative data achieved from the study—via four open-ended questions—was stored and analyzed using the Atlas. Ti (version 8) software, and conventional content analysis was conducted.[25] First, all of the data were read repeatedly, to obtain a sense of the whole picture. Next, the data were read word-by-word to derive codes, initial themes and categories were labeled using an open coding process, and new insights emerged through an inductive category development process. The initial analysis was also reviewed, and labels for codes emerged from more than one key thought, deriving mostly from the respondents' wording.[26] Codes were then grouped but also sorted into categories, based on their relationship and conceptual linkage. In addition, the respondents' quotations were cross analyzed through their demographic characteristics and their responses to the closed-ended questions in the questionnaire. As this study used anonymized data obtained via questionnaires, it pursued a qualitative descriptive approach of content analysis and employed a relatively low level of interpretation. This is in contrast to a grounded theory or hermeneutic phenomenology that requires a higher level of interpretive complexity and are more suitable for in-depth interviews.[27]

Ethical considerations

The research participants received a link to the survey with the following message:

> We would appreciate your participation in a study that is being carried out by the University of Haifa and which focuses on the work on practicing nurses and nursing interns during the COVID-19 outbreak. To complete a short and anonymous survey please click on the following link.

After the potential participants clicked on the link, they received an explanation page detailing the purposes and significance of the study, the researcher's background, the structure of the survey, its ethical approval, funding issues, and protection of privacy and anonymity of participants. Participants were asked to give their consent for completing the survey by choosing either Yes or No, following a specific acknowledgment that they can stop their participation at any time. Only after agreeing to participate could they continue to the next page of the online survey, where they were able to answer the specific questions.

Completing the questionnaire did not entail distress or an emotional burden. Full consideration of privacy and confidentiality issues were also secured. The survey was deposited in the protected LIME-SURVEY system, managed by the Computing Department of the University of Haifa. Each completed questionnaire was assigned a number, with no identifying information being related to it. All information

obtained from the participants was coded and saved on the researcher's computer. No other use of the information was made.

The whole research program was pre-approved by the university's Ethics Committee of the Faculty of Social Welfare and Health Sciences at the University of Haifa, Israel (approval # 146/20, dated 10 April 2020).

Results

Respondents' characteristics

Of the 430 questionnaires submitted online, 231 had been completed correctly and were fully analyzed. Given that the study population is very specific and limited (registered nurses and 4th year students at our university) and that in this early exploratory study there was little value to base sample size calculation, the sample obtained met the statistical requirements for this research.[28]

The research sample was predominantly female (82.5%), Jewish (74.4%), and Israeli born (71.4%). The mean age was 41 (SD = 12). The majority of the respondents were married (60.7%) and secular (54%), with an average of 17 years' education (SD = 3) and 14 years' work experience (SD = 12). Most respondents were registered nurses (86.3%) from various fields of specializations and who worked in several departments, mostly in government (42.7%) or public (31.8%) hospitals. Out of 231 participants, 41 (17.7%) worked directly with COVID-19 patients, while the remainder mainly worked in hospital-based settings where patients may also be positive for COVID-19. The participants' main characteristics are described in Table 1.

Five major themes were discovered following the analytic process: Working as a nurse during COVID-19; Fears associated with working as a nurse during COVID-19; Being asked to perform unfair activities or requirements; Issues of the utmost concern for nurses during COVID-19; and ethical dilemmas. The following section expands on each of these themes.

Working as a nurse during COVID-19

Respondents were asked to describe how they regard their work as a nurse during this period of the COVID-19 outbreak. The most frequent words used to reply to this question were: *challenging* (37 times used), *difficult* (15 times used), *pressuring* (12 times used), and *frightening* (10 times used).

A significant number of responses (29.5% of quotations) referred to the characteristics and definitions of nursing during the pandemic. These included nursing being perceived as difficult, busy, pressuring, different, frightening, and with additional restrictions. It was also regarded as important, meaningful, having a unique value, high dedication and a mission to help others, responsible, reflecting the relevancy of the nursing profession, being appreciated, being seen, gratifying, and leading to feeling proud. Other work characteristics of the nursing profession during the pandemic included phrases such as unclear, unanticipated, dynamic with guidelines being frequently changed, and accompanied by numerous dilemmas. Quotations in this category referred to the work remaining the same but with added protective guidelines or risk, a demand for vast knowledge and experience, the need to continuously learn about the virus and how to manage it, exhausting, requiring constant concentration, and requiring vast patience for providing care to patients who are at-risk, scared, or lonely.

Such replies emphasize nurses' capability to show compassion, support patients and make them happy, skills for communicating with patients and their families, physical ability to function throughout twelve-hours shifts, and the mental capacity for dealing with patients. Some special skills were mentioned, relating to work that is challenging with regards to patients who are accompanied by friends or family—as this

Table 1. Participant characteristics.

Gender	82.5% Female; 17.5% Male.
Age (years)	41 (Average); 22-65 (Range); 12 (SD).
Country of Birth	71.4% (Israel); 22.5% (USSR previously); 6.1% (Other countries).
Marital Status	60.7% Married; 21.5% Single; 11.2% Divorced; 4.2% in Partnership; 1.4% Separated; 1% Widow.
Nationality	74.4% Jewish; 24.2% Arabs; 1.4% Circassion.
Religiosity	54% Secular; 28.4% Traditional; 13.5% Religious; 4.1% Ultra Orthodox Jews.
Education level (years)	17 (Average); 12-30 (Range); 3 (SD).
Work Experience(Years)	14 (Average); 0-50 (Range); 12 (SD).
Specialization	55.2% Varied specializations (Obesity, Psychiatry, Risk Management, Geriatric Medicine, Oncology etc.); 31% Intensive Care (Adults, respiratory, children, neonatal); 8.6%Emergency Medicine; 5.2% Public Health (Infection prevention, epidemiology etc.)
Type of Healthcare organization	42.7% Governmental hospitals; 31.8% public hospitals; 12.7% Sickness funds; 7.7% Private hospitals; 2.3% Family Health Clinics; 1.8% Homes for the elderly; 1% Army clinics
Department Type	38.4% Varied Departments; 14.9% Internal Medicine; 10.9% Intensive Care (Adults, respiratory, children, neonatal); 9.5% Emergency Medicine; 6.8% Delivery Department; 6.8% Community Clinic; 5.4% Chirurgic Departments; 4.1% Children's Departments; 3.2% Operating Rooms
Department Size (Number of people)	28 (Average); 1-100 (Range); 18 (SD)
Geographical Area	49.1% Northern area; 24.6% Central area; 10.5% Southern area; 9.6% Hasharon area; 6.2% Jerusalem area
Professional Status	86.3% licensed nurses; 23.7% Interns (4th year nursing students)
Ranking of Participating Nurses	37.5% Staff nurse; 20.8% Unit nurse manager; 38.7% Clinical specialist/nurse; 3% Staff/Nurse educator;

requires paying more attention than to patients without visitors. On the other hand, for some nurses, it was reported less stressful having to care for fewer patients.

Another significant portion of responses (29% of quotations) pointed to the unique working conditions posed by the pandemic. These included hygiene strictness, taking protective measures, a shortage in medical resources, fear, inadequate or insufficient protective equipment, long and intensive shifts, large workloads, fewer staff, stress, tiredness, tele/e-medicine, uncertainty, and a lack of support.

Other responses (23.5% of quotations) referred to the mental and emotional implications of working as a nurse during the COVID-19 outbreak. These emphasized the pressure, excessive emotional burden, challenge, anxiety, frustration as a result of not truly knowing how to treat patients, slight depression, aggression, stress, testing out the adapting to difficult situations and functioning within them, eroding self-confidence in providing care, and confusion. These implications were associated with severe protective measures and guidelines, logistics and family demands, lack of organizational support, the threat of con-tamination from patients and staff, risk, fewer staff as a result of quarantines or being transferred to other departments, and a high volume of patients in some departments. It was also linked to irregular and uncertain work schedule, uncertainty, panic, organizational chaos, difficulties that stem from guidelines, vast bureaucracy, physical challenge, emotional burden, insufficient or inappropriate protective equipment, and poor coordination between community and hospitals.

Interestingly, concepts of difficult work, greater tension, and having a greater responsibility toward patients during this period were mentioned more frequently by respondents who work in private hospitals compared to those who work at public or government hospitals. Respondents who greatly agreed with the statement that caring for sick/carrier patients comprises an extensive emotional burden specifically

described their work during the COVID-19 outbreak as scary, challenging, and difficult—compared to other nurses. On the other hand, respondents who referred to their duty to help society as the most important motivational factor for working as a nurse during these times referred to concepts such as great responsibility and appreciation for the nursing profession and its associated challenges during the COVID-19 more than nurses who refer to other motivational factors.

Fears associated with working as a nurse during COVID-19

When asked about fears that stem from working as nurses during the COVID-19 outbreak, the respondents provided a range of answers. The most prevalent response (27.9% of quotations) referred to nurses' personal risk, that is, contracting the virus. Most worried about contracting it from patients; only 1.9% of quotations referred to contracting the virus from a member of staff.

Only 0.4% of quotations referred to fear of the disease itself. Instead, personal risk was usually (22.6% of quotations) linked to infecting their loved ones (especially family members), which seems to be the focus of this concern. Personal risk was also frequently mentioned in reference to unsuitable, insufficient, or inadequate personal protective equipment, and as the essence of the patient-nurse relationship during this period. It is important to note, however, that 12% of quotations expressed a lack of fear.

In relation to fear, the second largest category of codes (15.8% of quotations) referred to by the respondents related to dilemmas regarding care provision or patients. Some of these dilemmas were also ethical. This category included fear of violence against nurses; a lack of confidence in the care provided; patients not receiving adequate care and their condition worsening as a result; making mistakes or medical errors or harming a patient; not objecting to another member of staff who should be wearing more protective equipment; the inability to emotionally cope and contain patients; caring for patients who do not comply with protective instructions; caring for ventilated patients without experience or protective equipment; infecting patients who were negative prior to admission; infecting other patients in complex situations; not knowing or doing the maximum they could for patients because of a lack of resources; patient death; patient deterioration; and a working environment (busyness, tiredness) which promotes failures or mistakes.

Nurses who strongly agreed with the statement that they are afraid to care for all patients in the health system during the pandemic were predominantly concerned with possible contamination and the lack of personal protective measures, compared to other nurses. Their quotes referred to contracting the virus themselves or infecting others (family, friends).

Being asked to perform unfair activities or requirements

Respondents were asked to write whether they are required to perform certain activities or actions which they regard as unfair. On average, 38.6% of quotations of all replies to this question explicitly stated that they had been given no such activities or requirements. Of the respondents who strongly agree that the health system is respectful of their work decisions during this period, as high as 77.8% of quotations presented by them stated that they had not been asked to perform unfair actions. This is compared to 30.6% of quotations from respondents who totally disagree with such a statement.

The quotations of respondents who did refer to unfair activities or requirements can be divided into three areas: (1) nurses' personal issues/concerns, (2) nurses' relationships with their manager/hospital/state, and (3) nurses' duty to provide care.

The category of nurses' personal issues/concerns usually referred to issues concerning the personal protection of nurses from possible contraction of the virus. Examples of quotations from the first area include, "Working with patients suspected to have COVID-19 without a protective gown in a crowded room"; "Recycling protective equipment and not changing operating masks every two hours"; and

"Working with COVID-19 patients even though I belong to an at-risk population." As explained by one respondent:

> "In the emergency department we admit many women and spouses and there is great exposure. We don't get N95 masks but simple surgical masks, and there is a shortage of protective equipment, including non-penetrable gowns. This leads to a feeling of irresponsibility and anger towards those who should be protecting us."

The second category concerns nurses' relationships with their employers, or in some cases, with the hospital or state as well. This category includes two sub-categories. The first has to do with general observations pertaining to such a relationship and its effect on nurses in general and on nurses' rights in particular. The second sub-category includes specific comments regarding instructions or actions given by the nurses' employers.

Examples of the first sub-category include the following: "Working irregular hours that are not permanent working hours. Adding many responsibilities. No information regarding payment for extra hours and new responsibilities that are placed on the nurse."; "Not taking care of my children and work twelve-hours shifts."; "I refused working twelve hours without a break but my supervisor is making faces on me"; "payment is the same for those who are exposed to verified patients."; "to report vacation days for lack of working hours as a requirement of the Ministry of Health"; "if we are under quarantine it will be on our sick or vacation days"; and "they asked me to work only twelve hours' night shifts. I raise alone two children, and although they are big, I believe it's unfair." More examples are provided in the following examples:

> "It's unfair not to ask if we have needs at home. We don't belong to the system. We have homes and families and we need help with simple assignments such as buying groceries, because after twelve-hours shifts, who has the energy to shop, cook, or clean? And 24 hours later, you do it all again. No one cares how we're doing. They treat us like manpower, not humans."

> "In addition to the obvious health crisis, there are constrains of the educational frameworks that force our children to stay at home. The system is not ready and does not want to help with this kind of problem and to provide some kind of answers in terms of work arrangements. But it expects to receive the regular working hours from us. This is completely absurd."

> "It's unfair to cut staff at times like these, and having to work with a lack of hours, reduction in shifts in accordance to workload in department, and as a result to wage reduction . . . and when it is convenient for them—to add shifts above and beyond. Everything according to the needs of the system."

> "As a nursing student who is doing her internship in nursing, it's unfair to ask me to do a 12-hour shift since I do this intensive shift with no financial compensation and no one cares how I get here and how I get home after my shift. In addition, I think it's unfair to ask me to wear my own uniform from home and wash it in my own washing machine these days. They should give me uniforms at hospital rather than make me indirectly infect a family member."

Examples of the second sub-category include the following: "Doing things that are not nursing!! Opening emergency files instead of a coordinator or transferring laundry or equipment instead of a nursing assistant"; "Forcing us to work at a site with COVID-19 patients"; "It's unfair to send us to the work site without training and to set up a maximum time for overall testing"; "Caring for patients without having certain knowledge, such as patients on ventilators"; "Instructions are being changed frequently"; "Have to continue with the work routine and admitting patients as usual."
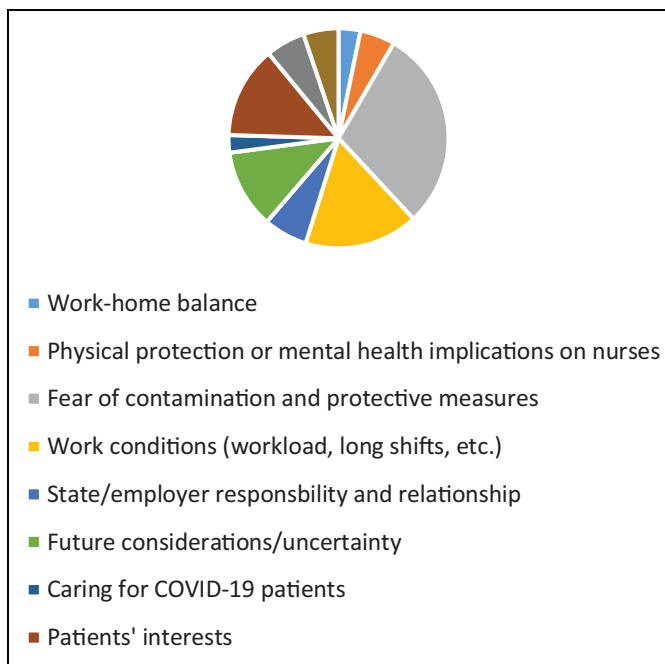
Figure 1. Nurses' areas of concerns.

Examples of the third area (nurses' duty of care) are few and include the following: "Performing certain actions without adequate training"; "Taking someone's temperature not from a distance"; and "Staying close to a patient who is not in an emergency case."

While the percentage of male respondents who stated that they were not asked to perform unfair activities is similar to that of female respondents (around 40%), male respondents did not refer to issues relating to work-home balance/conflict or to requests for forgoing caring for their children or performing home responsibilities. Instead, they mostly provided quotes pertaining to providing care with insufficient or inadequate protective measures.

Issues of the utmost concern for nurses during COVID-19

In the open-ended questions, where respondents could refer to current areas of concern, only 0.05% of the quotations referred to being worried or disturbed by anything. The most common area of concern was their being protected from the virus, as well as worrying about their own personal and protective equipment (30% of quotations). The second and third most frequent theme of concern was working conditions (17% of quotations) and patients' interests (14%).

With regards to the previous question asked, "Are there any activities or requirements that are unfair to ask you to perform during the pandemic?" the respondents expressed their frustration, disappointment, and anger toward their employers in great detail, especially regarding protection of their rights. In contrast, for this question, only 6% of quotations referred to this category as being the area which most concerns nurses.

Figure 1 presents all areas of concern and their percentages, based on the respondents' answers.

Of the Arab nurses who responded to the questionnaire, 73% of quotations referred to issues of con-tracting the virus and infecting others, as well as personal protective measures. This is compared to 56.2% of

quotations provided by Jewish nurses regarding these issues. Similar gaps in the rate of these responses were found between religious (72.7% of quotations) and secular (50.5% of quotations) nurses. Furthermore, respondents who greatly agree with the statement that they feel protected from contamination at work were mostly concerned by their work conditions and patient-related issues. The more respondents felt less protected at work, the less they were concerned with these issues, and the more they were bothered by protective measures for ensuring their personal safety. However, respondents who ranked their level of risk for contamination the highest (10 on a 1–10 scale) were not only worried about protective measures or contamination, but also about work conditions and more general worries pertaining to the pandemic.

Ethical dilemmas

From the nurses' responses to the 4 open-ended questions, 22 ethical dilemmas were identified and are divided into 6 categories:

1. Providing care despite the risk to oneself and others—specifically contaminating partners or family members, or forgoing one's familial responsibilities as a result of quarantine or the disease: "A choice between life and death"; "Being in constant fear of self-contamination and contaminating others"; "If I contract the virus, what will happen to my family or parents?" "I'm not afraid of COVID-19. I'm just worried about my children."
2. Providing care without adequate material/monetary compensation or managerial support and appreciation: "As a new nurse who also suffers from asthma, I have to fight to survive and receive my rights, instead of benefiting from the system moving COVID-19 patients to appropriate wards."
3. Providing optimal care in cases of uncertainty, lack of knowledge, denial, and shame: "I worry about not providing optimal care"; "I'm afraid of making mistakes"; "Hospitalized patients don't tell the truth about their condition"; "Patients are not truthful about their exposure to people with COVID-19."
4. Providing care in hard conditions: "Every time I put on my protective gown before entering, I look in the mirror and ask myself, what am I walking into? Why am I doing this? I never expected to experience such a situation. I may be a new nurse with only 1.8 years of experience, but my concerns are the same as most of the staff that I work with."
5. Providing care despite contentious objections: "The hospital expects us to separate between babies and their mothers if they are sick or suspected as being positive for COVID-19. Most of us object doing this."
6. Placing great emphasis on COVID-19 at the cost of other diseases/conditions: "I'm afraid that other patients neglect themselves for fear of coming to the clinic/hospital"; "Clinics are closed and empty and you need to provide telephone support instead, which is more difficult. Patients are desperate and frustrated."

Discussion

Analysis of the four open-ended questions revealed a complexity that is characteristic of the conflict between nurses' duty to provide patients with care and their responsibility to society on the one hand, and their right to self-care in times of a pandemic on the other hand. This is in addition to their multiple areas of concern, the large spectrum of experiences linked to activities and actions required of them, and their need for support. Many of the findings of this research correspond with healthcare providers' sources of anxiety and key concerns during COVID-19, as discussed in the literature,[9,29] specifically high perception of personal risk.[30] Combining these findings with the other questions from the survey[15] exposes high
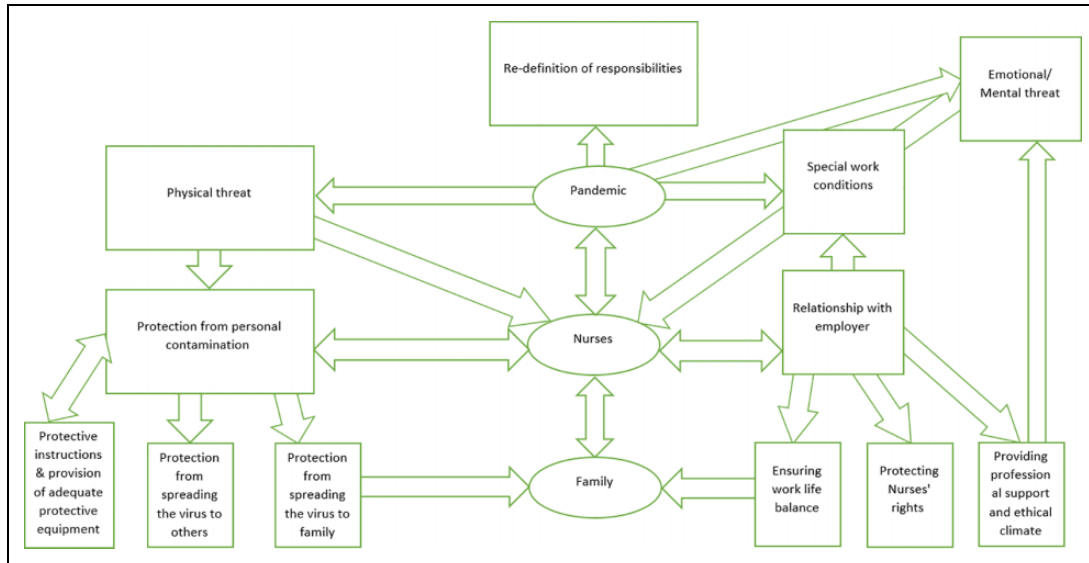
Figure 2. Conceptual understanding of nurses' clinical and ethical competency during COVID-19.

motivation to provide care and concerns not only about themselves and their families, but about their patients and colleagues as well. It also validates nurses' special role in providing a calm and positive care environment for their patients, and moderating patients' isolation and dehumanizing scenarios that are associated with wearing personal protective equipment or not being able to conduct face-to-face communications during this period.[31]

However, a review of the content provided by nurses in this research demonstrates that performing their duty of providing care may be at the cost of protecting their own health and safety, as stipulated, for example, in the Code of Ethics for nurses[32] and more specifically by the American Nurses Association.[33] Moreover, their frustration and disappointment following their employers' attitudes during these difficult times portray a worrying denial of the relational dimension of their care activities, their being vulnerable, interdependent, and connected to others.[34] It further exposes how their rational judgment and positioning at this time, reflected in their attempts to protect their salary and work conditions, is filled with employers' ignorance and lack of appreciation. In turn, this situation deprives nurses of the opportunity to enhance their moral identity and need for professional satisfaction.[35]

Following Strauss and Corbin[36] and Charmaz,[26] Figure 2 depicts a conceptual diagram for developing a theoretical schema grounded in the data—specifically codes, group codes, and the relationship between them.

As depicted in Figure 2, nurses' clinical and ethical competency during the pandemic is mutually interrelated by their relationship with their employers and family, as well as by their concerns relating to their own personal protection from the virus and their general attitude toward the pandemic. It is also affected by physical and emotional risks, the latter being influenced by their perception of the pandemic. Nurses' relationships with their employers center on four main areas: Protecting nurses' rights; providing professional support and an ethical climate, which affects nurses' emotional and mental feelings of threat; designing special work conditions, which are also molded by the pandemic; and ensuring a positive work-life balance, which in turn also affects their relationships with their families. Nurses' feelings of being protected from personal contamination is influenced by the actual physical threat and is mutually

interrelated with protective guidelines and the provision of adequate protective equipment. In turn, this feeling of self-protection affects their feeling of being protected from spreading the virus to patients and colleagues and also, more weightedly, to their family. Finally, the pandemic also affects and constitutes the redefinition of nurses' responsibilities and unique work characteristics during a pandemic and compared to routine medicine.

Nurses' concerns expressed in this research are reflected in ethical and professional dilemmas and feelings of discomfort, frustration, and even anger common to this era.[37] Studies in this field also found that a large portion of nurses did not feel that ethical conflicts were openly addressed, that they had no organizational resource or process to help them with their ethical concerns, and that there are ethical issues that they cannot do anything about. Nurses who reported more ethical stress showed lower job satisfaction and higher intent to leave their current position.[38,39]

From this aspect, the literature emphasizes that managing ethical concerns can best be achieved through a positive ethical climate and institutional support,[40,41] yet this does not seem to be the case here. Studies further show that work-home interference and conflict are a source of turnover intentions among new nurses.[42] This finding is especially significant given the aging workforce in nursing.[43] Nurses should be trained and encouraged to develop and experience problem-focused coping strategies through which they can reduce or eliminate stress factors through problem-solving, cost-benefit analysis, and time management. Such strategies are negatively associated with work-home conflicts and are positively associated with role engagement and cross-domain enrichment.[44,45] More fundamentally, nurses should develop their moral consciousness and build their moral resilience through gradual training, reflection, and increased communications with and attention from their colleagues and managers,[46,47] thereby feeling more confident to control their discomfort and stressful situations while providing medical care and functioning as family members.[38]

Our research suggests that employers and health-managers do not employ strategies for promoting work conditions and allowing a better fit between nurses' personal needs and their work demands in times of pandemics. Other than its harm to nurses, this may increase their involvement in interpersonal conflicts and reduced quality of interpersonal relationships with colleagues and employers.[39] It is recommended that managers employ a varied means of strategies to manage these ethical and personal conflicts that may arise from macro crises such as COVID-19. These strategies should apply before and during such crises. Strategies prior to such events include, for example, the development of policies and practices to help nurses effectively manage their work and family life, and the training of managers on the importance of compassion and rewarding compassionate behaviors of supervisors. Strategies during such events include, for example, being supportive of nurses' preferences and needs with regards to their work-family relationship, providing real time coping tips for managing ethical dilemmas and work-home conflicts, and so on.[45] It could also be highly meaningful to provide nurses with social support when needed, enable them to practice their responses to ethical dilemmas and organizational hardship, while controlling their negative emotions through catharsis and concentration.[46]

This research emphasizes that other than providing nurses with a safe work environment during pandemics, it is of great importance that nurses feel their voice matters and their work-related rights are respected—much more than in routine medicine. For decades, nurses have struggled balancing between their ethos of selfless care and dedication and their claim for professional recognition and fair working conditions and wages.[48] This complex tension, which is also shaped by nurses' association with female caring similar to other unpaid labor, is aggravated at times of pandemic where nurses are allegedly expected to concentrate on their utmost commitment to care.[49] In Israel, hospitals provided free childcare services for medical staff during the COVID-19 pandemic, operated by soldiers and volunteers and financed by the State, local councils, or the healthcare funds. Governments should adopt varied measures to help nurses who are also parents, especially women who shoulder much of the burden at home, making also the vast majority of the healthcare workforce, in managing their responsibilities through mechanisms of increased financial and social support.[50]

Limitations

The study has several limitations. First, the use of open-ended questions with the researcher's limited ability to probe may have limited the generating of in-depth information compared to face-to-face in-depth interviews about the investigated phenomenon and the quality of the data presented. Moreover, asking participants to answer only four open-ended questions may not provide sufficient room for in-depth exploration of important issues. While these considerations are important, the large number of the questionnaires that were analyzed in this study, combined with the thorough analysis of the relationship between the responses to these open-ended questions and the close-ended ones provide rich and varied content, thereby guaranteeing a valid and well-structured qualitative research. Moreover, content analysis of anonymized data that is obtained via questionnaires is a relatively easy process and eliminates lengthy and subjective procedures, such as in-depth interviews, which may lead to bias and affect the interaction between researcher and participants.

Conclusion

This research explored that a significant portion of nurses reported that they did not feel adequately supported and protected in their work environment during COVID-19. Moreover, some regarded major requirements as unfair and even exploiting. Much focus has been placed on nurses' need to preserve and maintain a balance between home and work on the one hand, while looking out for their household in light of their increased risk at work on the other hand. The lack of ethical climate and institutional support combined with a disrupted work-home balance constitutes a serious threat to nurses' careers and overall satisfaction from their career choice and may also affect their quality of care. Nurses deserve full recognition and promotion of their rights at work, so that they could thrive and offer the best care, while feeling happy and proud to fill this position.

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