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ORIGINAL ARTICLE

Nurses' experiences of providing ethical care to the patients with COVID-19: A phenomenological study

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Summary

Introduction. – Coronavirus disease (COVID-19) is a newly emerging infectious disease that bringing a heavy workload on nursing staff.

Objective. – This study explores the nurses' experiences of providing ethical care for patients with COVID-19.

Methods. – This qualitative study was carried out based on hermeneutic phenomenology. Unstructured interviews were conducted with 18 Iranian nurses. Data were analyzed based on the hermeneutic approach using the Diekelmann approach.

Results. – Three themes emerged: strong clinical dilemma, flourishing of professional values, and strengthening human and organizational communication.

Conclusion. – The findings highlight ethical care and its dimensions for COVID-19 patients. Nurses need support from health managers to provide ethical care in such health crises.

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Introduction

Ethical care is a distinctive approach to moral theory that focuses on the importance of responsibility, concern, relationship over outcomes, and rules. In the last three decades, ethical care has occupied an important place in nursing. Ethical care is fundamental to effective and safe care [1,2]. It is believed that being a nurse is an ethical endeavor, and almost every decision made by a nurse has an ethical dimension [3]. Nursing activities are mainly based on an ethical commitment to provide quality and safe care, and care based on such an ethical commitment is vital in performing and continuing these activities [4].

However, nurses face many challenges in the provision of ethical care for their patients. Limited time and high workload are among the challenges that can restrict the nurses' ability to provide ethical care, make them emotionally exhausted, and reduce their ethical sensitivity in the care of their patients [5]. In recent months, one of the challenges nurses face is dealing with COVID-19, the disease that has increasingly become a life-threatening factor with a global prevalence and an international concern [6]. Given the many treatment options, most of which are still in trial and with conflicting results, nurses are concerned about providing ethical care to their patients in the current situation. Barlow et al. (2018) reported that nurses base their ethical reasoning and decisions on their beliefs and values, overcome the ethical dilemmas posed by political and organizational macro- and micro-decisions, and the complex and expensive treatment options. Therefore, they intervene based on ethical frameworks and theories such as ethical care and virtue ethics [7].

As noted, nurses are affected by ethical issues resulted from the effects of COVID-19 on patients, families, and the health care system. Worries about safety and access to personal protective equipment, and the availability of ventilators and medications needed to support patients with COVID-19, are among issues that put great ethical distress on nurses. Kim et al. (2015) have also reported that concerns about providing ethical care to critically ill patients put severe physical and psychological pressure on nurses and reduce the quality of their professional life [8]. During the MERS-CoV pandemic epidemic, nurses often experience significant physical and psychological pain due to a sense of responsibility and professional ethics [9]. However, a study showed during the MERS-CoV outbreak; emergency nurses had experienced ethical problems due to their mindset of avoiding patients. This avoidance was influenced by their cognitions of social stigmatization, level of agreement with infection control measures, and perceived risk [9].

Most Iranian nurses have been trained to care for people with a wide range of life-threatening conditions. However, they have never experienced a pandemic disease such as COVID-19. Now, they are at the forefront of the war against coronavirus. Therefore, they face the ethical care challenge of properly allocating health care resources and providing quality and ethical care to these patients. This challenge will be especially evident when nurses are under constant pressure to protect the health of themselves, their families, colleagues, and patients' families while providing quality care to COVID-19 patients. On the other hand, nurses are frequently facing the painful scenario of patients' death in

isolation and often without the presence of their families. These issues can concern nurses and expose them to ethical distress due to dehumanization and care provided outside of the code of ethics defined for nursing practice [10].

As COVID-19 is expected to remain a pandemic for the next few months and cause many hospitalizations, nurses remain in an atmosphere of stress and ambiguity about the future of their professional ethics. In the current situation, the standards of care and treatment of COVID-19 are constantly changing. The care guidelines are often different from the nurses' routines, which put nurses in the dilemmas of ethical care for these patients.

Our knowledge is limited in ethical care for patients with COVID-19. The main focus of studies is on issues such as nurses' knowledge and anxiety [6], nursing strategies for centralized treatment [11], and developing holistic care guidelines for patients with severe COVID-19 [11]. However, few studies are available on the nurses' experiences in the ups and downs of ethical care for COVID-19. Therefore, the research question was: What experiences do nurses have with ethical caring for patients with Covid-19? Then, this study was conducted to explore the nurses' experiences of providing ethical care for patients with COVID-19.

Methods

This qualitative study was carried out based on hermeneutic phenomenology. Hermeneutics is a systematic approach to studying a phenomenon. It permits a phenomenon to be studied with an interpretative approach and reaches a deep perception of the people's lived experiences [12].

Setting and participants

The study setting included the teaching hospital of Qom city, which was the primary source of the COVID-19 outbreak in Iran. Participants were selected using the purposeful sampling method [13]. A total of 18 nurses with diverse backgrounds participated in the study. The participants differed in gender, education level, job positions, and work setting, and their clinical experience ranged from 3 to 15 years (Table 1). Inclusion criteria were having a bachelor's or higher degree in nursing, at least three years

Table 1 Characteristics of participants ($n = 18$).

Characteristics	Head title	Frequency or mean \pm SD
Gender	Male	7
	Female	11
Age (years)		31.65 \pm 7.2
Clinical experience (years)		6.58 \pm 5.71
Education	Bachelor's degree	14
	Associate's degree	4
Position	General nurse	15
	Head nurse	3
Work setting	General Ward	11
	Intensive care units	7

of work experience as a nurse, speaking in Persian, and participating in the study.

Data collection

Unstructured interviews were conducted with participants who met the eligibility criteria. The interviews were conducted from April 1 to May 30, 2020. Two individual interviews were conducted with each participant. The interview began with an open-ended question and if necessary, semi-structured with closed-ended questions were used [14]. All interviews were conducted in the Persian language. Each interview lasted for 30–50 min. Due to the difficulty of the interview, while the nurses were in isolation and wearing personal protective clothing, most of the interviews were conducted in the nurses' restroom.

The interview guide included open-ended questions as follows: (1) "What is your experience of caring for a patient with COVID-19?". To elicit further details, semistructured questions and also probing were conducted during interviews: (1) "Please explain to me about the ethical issues you experienced in caring for a patient with COVID-19." (2) "Can you explain the ethical challenges you experienced in caring for patients with COVID-19?" Additional questions were asked based on the nurses' responses [15]. Data saturation was achieved with 16 participants. This was when no new conceptual code emerged from the data [16]. All interviews were audio-taped with permission from the participants and were transcribed verbatim on the same day.

Data analysis

Soon after the first interview and simultaneous with data collection, data analysis was started using the seven-steps Diekmann, Allen, and Tanner approach as follows: 1. The transcripts were read several times to gain an overall understanding of them; 2. Interpretive summaries were written of every interview to identify the main themes. Then, exemplar quotations were added to the summaries to support the interpretations; 3. Finally, the research team discussed the interpretations, extracted themes, discussed the disagreements, and reached a consensus about the sub-themes and themes. Later interviews shed more light on or completed the themes obtained from the earlier interviews.

In some cases, new themes emerged, and the interpretations were expanded; 4. In case of disagreements about the interpretations, the research team returned to the original text to resolve the inconsistencies; 5. The common meanings were determined and described through comparing and contrasting the interview transcripts; 6. A constitutive pattern was extracted by identifying the relationship between themes; 7. A draft of the themes and items selected from each interview was provided to the interpretation team members. The feedbacks were used to achieve the final version of the themes [12].

Trustworthiness

Credibility was established through maximum variation sampling, selecting the most suitable meaning units, member checking, peer checking, and prolonged engagement with the participants and the data. In the second interview, the

text of the first interview was given to the concerned participants to affirm what they said in the first interview. For peer checking, two expert supervisors checked the analysis process. If disagreements occurred, discussions were held to reach a consensus. Prolonged engagement with the participants helped the researcher to acquire a better insight into the phenomenon under the study. In addition, the contextual features of the participants were provided to help readers decide on the transferability of the findings.

Ethical consideration

The Ethics Committee approved this study of *Qom University of Medical Sciences*, Iran (approval code: IR.MUQ.REC.1399.014). First, participants were informed about the study aim, voluntary participation, and the right to withdraw from the study. Then, personal informed consent was obtained verbally from each of them. Permission was obtained from the participants for audio recording.

Results

Three themes and ten subthemes emerged from the participants' experiences of providing ethical care for patients with COVID-19 (Table 2).

Strong clinical dilemma

Nurses were confused by facing an unknown disease and the lack of accurate information. Confusion and denial of reality led to numerous and significant indecision for some participants.

Wrong information about the disease

Participants stated that overconfidence in the data received from the first countries involved in the disease and misconceptions about the disease led to extreme fear of the illness and limited their ability to make proper clinical decisions. Nurses believed that they could provide better and quality care to these patients if they had more accurate information about COVID-19.

"At first, we were very wrong about the disease. We had received a very horrible picture of the disease. We thought anyone who came to the hospital with the disease would probably die; this has made us very anxious. But now we realized that the information we have received was wrong" (p. 12).

Facing the unknown disease

Participants' experiences showed that lack of knowledge about the new disease, failure of treatment plans that were successful in similar diseases such as the flu, and rapidly changing guidelines which were sometimes contradictory, caused them to be confused in choosing a suitable treatment and ethical care plan. Also, they feared that protective equipment such as masks and grenades would keep them completely safe.

"This is a new disease; no one knows it for sure. All treatments are empirical, and based on experience... guidelines

Table 2 Themes and subthemes extracted from the nurses' experiences in care for patients with COVID-19.

Example of coding	Subthemes	Themes
The disease is not dangerous Not knowing the proper care and isolation plan Lack of specific and reliable treatments High lethality of the disease Frequent change of treatment and control protocols	Wrong information about the disease Facing the unknown disease Denial of the reality	Strong clinical dilemma
Execution of professional commitment Sacrifice alongside the professional commitment Respect for patients' values and culture Great effort to heal patients	Being responsible Empathetic care Humanistic care Satisfaction with effective care	Flourishing of professional values
Creating a supportive atmosphere for colleagues Promote a team work culture Recognize the importance of the nursing profession in society Nurses' educational activities on social media Multidimensional presence of nurses in hospitals and society	Improving intra-professional communication Improving inter-professional communication Improving the communication between the nursing profession and society	Strengthening human and organizational communication

are constantly changing. A new guideline is announced every few days, all nurses and doctors are confused, I'm always worried about the right patient care." (p.3) another participant Stated:

"At first, I was very worried about catching the disease." (p.15)

Denial of the reality

Some participants acted as before the epidemic. They did not take the COVID-19 very seriously and did not change their previous practices. Some of them also believed they would not get the disease. At the beginning of the crisis, some participants denied that the disease is dangerous and highly contagious.

"I haven't changed much; I don't think that it's more dangerous than H1N1 flu, some colleagues are anxious, but I'm not. . . Although this disease is a bit strange, in general, patients with COVID-19 are no different from other patients; I do my job as before" (p. 5)

Flourishing of professional values

Participants believed that a sense of responsibility and adherence to professional values such as empathy, humanity, and altruism made nurses strive to provide the best possible care for patients with COVID-19.

Being responsible

Most of the participants stated that their work conscience and professional commitment have made them not only try

not to miss their shifts in this critical situation but also cover the shifts of colleagues who get sick. In addition, they also tried to prevent the spread of the disease by isolating the patients with COVID-19.

Nurses also did not forget their social roles and tried to play their social responsibility through community training via the web and mobile-based social networks.

Referring to their professional commitment to providing the best possible care, participants frequently said that patients with COVID-19 need more care and attention due to the rapid and unpredictable changes in the disease. Therefore, despite their long shifts and high workload, they try to provide the best care to our patients.

"We are at the forefront of the war against coronavirus and consider it as our national and social responsibility to protect the people against this disease. . . We have to fight to save people's lives." (p. 1)

Empathetic care

Most participants reported empathetic behavior with their patients. When they had wrong information in the early days, they were very worried about catching the illness. However, over time, their knowledge and experience of the disease had increased, and they had adapted to fear of the disease. According to the participants, overcoming the fears of the disease had allowed them to play an active role in providing empathetic care for their patients by getting closer to patients, talking to them, and actively listening to them.

"When my information improved, and I realized that patients are so lonely, worried, and lost their morale, I was able to get closer to the patients by overcoming my fears and anxiety. After that, I spend more time talking to these

patients. I hold their hands lovingly . . . I comfort them.” (p. 15)

Humanistic care

Participants’ experiences indicated that they followed nursing ethical codes despite the high workload and stress caused by working in a critical situation. They also respected patients’ values and beliefs and treated them fairly and without discrimination. Nurses gave priority to patient care. They had risked their lives to save patients. In other words, most of them had made sacrifices to keep the patient alive.

“Although I have diabetes and feel very tired because of the busy shifts, not only I don’t leave the patient, but I come to the hospital during peak hours to help people.” (p. 8)

“Although I have too many and busy shifts, I try to consider the conditions of patients. To me, it doesn’t matter what the ethnicity or language of the patient is. I have to take care of everyone equally.” (p. 10)

Satisfaction with effective care

Although the deaths of patients despite all medical and nursing efforts made nurses very upset, the recovery of some patients made nurses happy and satisfied. Moreover, it prompted them to increase their efforts to care for other patients.

“I feel good when I see my patient gets better and being discharged from the hospital. Seeing patients recover gave me a lot of motivation and helped me endure hardships.” (p. 2)

Strengthening human and organizational communication

According to the participants, caring for patients in such a critical situation has improved intra- and inter-professional relationships of healthcare professionals and improved the relationship between the nursing profession and society.

Improving intra-professional communication

Participants stated that working in crisis situations created an intimate atmosphere between them. In addition, participants’ experiences showed that working in critical situations made nurses kinder to each other and strengthened their friendship and cooperation.

For instance, after the onset of the COVID-19 crisis, nursing officials collaborated with clinical nurses in patient care in addition to their managerial duties.

“We all have one goal. We have come together to help patients. Wherever you look in the hospital, you can see the cooperation and intimacy of the nurses.” (p.6)

“Although our head nurse is very busy and under pressure, she helps us take care of our patients. When I’m tired, she gives me a break and does my works” (P. 3)

Improving inter-professional communication

Participants’ experiences indicated that working in critical situations, in addition to improving intra-professional

communication, led to improved inter-professional relationships and the promotion of a culture of teamwork. Moreover, they believed that it would be difficult to overcome a crisis without unity and empathy among health care professionals.

“The situation is the same for all staff; everyone is at risk for the disease; from the beginning, we realized that if we work better together and as a team, we would be less likely to get sick and more likely to recover the patients. . . The challenges of nurse-physician communication have been significantly decreased during this time.” (p. 9)

Improving the communication between the nursing profession and society

In addition to providing direct care to hospitalized patients, nurses tried to help control the pandemic and protect the community against COVID-19 through active participation in formal social media. According to the participants, good performance of nurses in such a critical and risky situation, and care of many of patients who referred to hospitals, strengthened the trust of community in them, improved their public image, and increased their interaction with community.

“In addition to work shifts, I had increased my presence on formal social media to increase people’s sensitivity to the disease and to be able to teach them prevention methods. . . Now I feel closer to the people, and they trust me” (p. 7)

Discussion

The results show that nurses had a strong clinical dilemma due to facing an unknown disease, receiving wrong medical information about the disease, and denying that the disease was not lethal. Under these circumstances, they faced challenging conditions in patient care. In the present study, nurses perceived dramatic changes in their clinical practice in the COVID-19 epidemic crisis. At the same time, it was announced that COVID-19 is similar to other diseases, and therefore, there is no need to change in nursing interventions. As nurses’ statements show, multiple, changing, and sometimes contradictory guidelines challenge them in choosing and implementing treatments. This situation was ambiguous for the nurses. Sun et al. (2020) showed that at the beginning of the COVID-19 epidemic in China nurses of COVID-19 patients were anxious because they did not have enough information about the disease and that it was not similar to other infectious diseases [17]. Kim et al. (2018) also examined the nurses’ experiences in the MERS-CoV epidemic showed that the nurses were frightened and confused due to facing an unfamiliar disease [18]. Nurses’ experiences of Ebola and MERS-CoV patients show that they also experienced negative psychological symptoms such as anxiety, hopelessness, and mood swings due to facing a lethal disease [19,20]. The results of our study and similar studies show that nurses experience psychological stresses at the beginning of an emerging disease. These stresses make it difficult for nurses to provide ethical care. These psychological stresses are facing unfamiliar disease, fear of own safety, challenging working conditions and unfamiliar environment, differences in guidelines, high workload, and lack of skills in providing safe care to the patients [21–23]. Nurses’ experiences in MERS-CoV epidemics also show that

frequent changes in disease control protocols have confused nurses [18].

Nurses described empathetic and humanitarian care as presenting the ethical values of their profession. In some situations, empathetic and humanistic nursing might be overshadowed by technological advances, outcome measures, decreased resources, and staff shortages; however, the results of the present study showed that in the crisis of COVID-19, and despite being too busy or physically ill, nurses had risked their lives to save their patients because patients' recovery was a priority for them. This suggests nurses have good insight into the empathetic and humanistic aspects of care and are sensitive to ethical care for patients with serious illnesses. In a study of humanistic nursing in acute care, Khademi et al. (2016) have also reported that professional values and sensitivity of the situation and the availability of time and support as basic prerequisites of care promotion play important roles in adopting a humanistic approach in nursing. Moreover, Khademi et al. have reported that nurses are sensitive to the principles of humanistic care despite their professional rights are usually violated by nurse managers [24]. Nurses' behaviors, such as trying to get closer to the patient, holding the patient's hand, and expressing emotions, as Watson emphasizes, create an atmosphere of mutual empathy because of the nurse and the patient [25]. In this regard, Mercer et al. (2002) have emphasized that ethical issues such as altruism and ethical behavior should not be overlooked in clinical practice. However, the cognitive and behavioral aspects of empathy attract the most attention [26].

Also, responsibility was identified as an important component in the flourishing of professional values. Our findings showed that nurses maintained their conscience and commitment to the profession and society, despite the pressure of overtime and long shifts. The sense of responsibility induces nurses to realize their professional capabilities and promote ethical care during the outbreak. It also improves their psychological adjustment to the crisis situation. Wu et al. (2012) have reported that nurses are more likely to accept challenging responsibilities, make extra efforts and stay at the job because of their organizational identity and commitment to the profession [27]. A review of the experiences of the anti-Ebola medical team and nurses of MERS-CoV patients shows that the nurses, despite having severe stress from being infected and not safe, had a high sense of responsibility to help the patients [18,19]. Also, The experience of New Zealand nurses in the Influenza A (H1N1) epidemic shows that nurses, despite their workload and fatigue, had a high sense of responsibility and accepted extra shifts [28].

Improvement of intra and inter-professional communication and communication between the nursing profession and society was one of the main themes from the nurses' experiences. These changes empowered nurses to provide ethical care. Intra and interprofessional collaborations have been fostered due to the nurses' intimate and healthy work climate. Intra and inter-professional relationships are important issues not only for nurses but also for the whole healthcare organization. Poor inter and intra professional relationships would lead to job dissatisfaction, leaving the profession, unhappiness [29], and decrease patient safety [30]. Our findings showed that the improvement of inter-professional

relationships during the COVID-19 crisis had enhanced the culture of teamwork in the healthcare settings. Nurses believed that such a culture can improve patient care and safety and protect healthcare providers against physical exhaustion and disease in such a difficult working condition. A study showed the nature of interprofessional interactions changes as teams pass through crises. In the pre-crisis period, interactions are based on mutual respect for expertise, in the crisis period, hierarchical interactions were expected, and a certain lack of civility are tolerated. However, divergent perceptions emerged among health professionals during the post-crisis period [31]. In line with other studies, the results of our study show that the medical team improved teamwork and adapted more effectively to challenging working conditions during epidemics with support and kindness to each other [17,18,22]. In addition, other sources of support for nurses during epidemics include support of recovering patients, family members, government, and community. Therefore, community support for nurses in epidemics is important [32–34]. The community's support for nurses was trying to provide care to many critically ill patients and the active presence of nurses in the community to control the spread of the disease. COVID-19 epidemic will make the community more familiar with the extent of the impact and various roles of the nursing profession in health.

Conclusion

This study's findings demonstrated nurses' lived experiences about providing ethical care for patients with COVID-19. The main themes of ethical care for patients with COVID-19 included strong clinical dilemmas, the flourishing of professional values, and improving human and organizational communication. The findings highlighted that providing ethical care in critical situations was important for nurses. Nurses need support from health managers to provide ethical care in such health crises. Further research is needed to explore other health professionals' experiences in providing ethical care to patients with COVID-19.

Limitations

The present study was conducted on explaining nurses' experiences in one of the provinces of Iran. To increase the generalizability of these results, it is suggested that in future research, nurses from various hospitals be included. Other limitations of our study were that participants did not have a reflective diary.

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Author contributions

All authors attest that they meet the current International Committee of Medical Journal Editors (ICMJE) criteria for Authorship.

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Disclosure of interest

The authors declare that they have no competing interest.

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