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Bereavement and Critical Incidents Involving Healthcare Professionals in Italy During COVID-19: The Importance of the Spiritual Dimension

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Abstract
This exploratory research investigated the work of healthcare professionals during the COVID-19 pandemic, highlighting the major critical aspects, including healthcare providers' needs as well as personal, professional, and social changes brought about by the pandemic upon both living and dying. In general, for many healthcare providers, the changes imposed by COVID-19 together with their inadequate training led to an excessive emotional load that caused high levels of stress and, consequently, the risk of burnout. In the present study, we wanted to investigate the impact of the COVID-19 pandemic on healthcare professionals and to explore if and how spirituality influenced their experience. We adopted a qualitative methodological design based on interpretative phenomenological analysis. The respondents were 15 healthcare professionals (12 general practitioners, 1 physician, and 2 nurses). This research was carried out in Italy during the first lockdown, that is, between March and September 2020. Following the analysis of participants' experiences, four main themes were created: (1) critical issues in healthcare, critical incidents, and changes in the attitudes and habits of general practitioners during the pandemic; (2) emotional experiences and primary needs during the emergency; (3) dying during the pandemic and new psychological symptoms in noninfected patients; and (4) resilience and the role of spirituality. Since healthcare professionals, and general practitioners more specifically, were extensively exposed to the dying process and to changes in the end-of-life scenario, the support offered by palliative care is desirable, in terms of both the special skills that palliative physicians can provide and the presence of psychologists as well as through death education.

Keywords COVID-19 · Healthcare professionals · General practitioners · Spirituality · Bereavement

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Introduction

During the COVID-19 pandemic, people in the West have been forced to confront their own mortality, notwithstanding the denial of death so characteristic of Western society. A recent study explored different ways people reacted to the pandemic from the standpoint of terror management theory (Pyszczynski et al., 2021), according to which people's reactions to COVID-19 are processes to manage terror as death awareness requires defensive operations that "make sense" (Pyszczynski et al., 1999, 2015; Solomon et al., 2000). The main problem of contemporary secularized society is the anthropological upheaval that led to a decline in thinking about death: the excessive focus on medical, biological, and scientific fields that have superseded the spiritual dimension. The ontological representation of death as total annihilation is derived from this generalized attitude (Testoni et al., 2015). Indeed, there are significant differences between thinking of death as complete annihilation and being sure that it is a passage or a transformation of one's personal identity. The two representations produce different effects, with the representation of death as annihilation producing greater pain. Conversely, the representation of death as a passage reduces distress, anxiety, and depression (Testoni et al., 2015). Spirituality and religiosity are related to this representation of death with behavior inherent to health, illness, and dying (Jim et al., 2015).

According to terror management theory, cultural and religious variables correlate with stable relationships and self-esteem, which together create the so-called tripartite security system that helps to manage the terror caused by the awareness of death (Hart & Shaver, 2005). Spirituality and religiosity inhere to the personal relationship of trust with God or with a higher entity, both perceived as omnipresent during daily experiences and as a guide to moral behavior (Koenig, 2015). The perception of meaning in life is derived from these dimensions, buffering angst, anxiety, and depression (Abdel-Khalek & Lester, 2012; Desrosiers et al., 2011; Norenzayan, 2013) and enhancing forgiveness, closeness towards other people, well-being, higher levels of life satisfaction, and resilience in distressing situations (Hackney & Sanders, 2003; Helm et al., 2000; Jonas & Fischer, 2006; Levin & Chatters, 1998; Ryan et al., 2005; Testoni et al., 2016). Further research explored the role of implicit components of spirituality and their effects in healthcare settings (Castro et al., 2019), showing how they can help professionals to cope with death and dying (Carey, 2021; Papadopoulos et al., 2021; Prazeres et al., 2021; Schmuck et al., 2021; Testoni et al., 2018).

Research showed that religiosity and spirituality helped people to cope with the COVID-19 pandemic (Kumar et al., 2022; Roman et al., 2020; Tolentino et al., 2022). During the first phases of the pandemic, the emotional load of healthcare professionals was particularly severe and had negative consequences. Frontline healthcare professionals experienced adverse psychological outcomes such as burnout, anxiety, fear of spreading the infection, depression, increased substance addiction, and PTSD (Dubey et al., 2020; Testoni et al., 2022). Kokou-Kpolou and colleagues (2020) compel researchers to invite physicians to pay attention to these traumatic experiences and to adopt a holistic approach not only towards clinical manifestations of prolonged pain but also towards the assessment and treatment of different cases.

In the present qualitative study, we wanted to investigate the impact of the COVID-19 pandemic on healthcare professionals and to explore if and how spirituality influenced their experience.

Table 1 Participants

Name	Age	Profession	Provenance
Carla	48	General practitioner	Brescia
Doris	35	General practitioner	Brescia
Virginia	58	General practitioner	Brescia
Simone	67	General practitioner	Brescia
Luciano	40	Medical guard	Padua
Sandro	37	General practitioner	Treviso
Riccardo	37	General practitioner	Brescia
Veronica	45	Nurse	Venice
Gino	56	General practitioner	Brescia
Silvio	38	General practitioner	Venice
Caterina	37	General practitioner	Venice
Sonia	57	General practitioner	Venice
Alex	66	General practitioner	Brescia
Linda	61	General practitioner	Brescia
Maria	50	Nurse	Venice

Objectives of the present research

This research was carried out in Italy during the first lockdown (March 2020–September 2020), during the most severe period of the pandemic. The specific aims of the study were to investigate the effects this experience produced on healthcare professionals; to identify in healthcare professionals the feelings, behaviors, and new operative methodologies they drew on to face the emergency; to explore the role of spirituality as a factor in resiliency; to identify the changes that the healthcare system needs to make in the management of emergencies; and to recognize, in particular, the relational and emotional skills needed to improve the quality of care for patients.

Participants and methodology

A group of 15 people—8 women (53%) and 7 men (47%)—participated in this research, with a mean age of 48 (ranging between 35 and 67) and a standard deviation of 10.95 (Table 1). They were divided as follows: 12 general practitioners working in three polyclinics, 1 physician from the Continuing Care Service (province of Padova), and 2 nurses from a hospital (province of Venice) working in two different wards (dialysis and oncology). The sampling method used in the research was convenience sampling (i.e., potential participants volunteered to participate in the research study; Gill, 2020). The research was conducted via individual semistructured interviews. The interviews fall within the interpretative phenomenological analysis (IPA) framework (Smith & Fieldsend, 2021). IPA requires in-depth interviews with primary witnesses with respect to the subject of the research, which allows researchers to formulate a plan, organize it into specific areas, and guide the interview in a way that leaves participants a certain degree of freedom to freely narrate their experience. IPA aims at voicing (through a reflection on participants' main experiences) and making sense (offered by the interpretation

of the material emerging from the interviews) of participants' experiences; this has a central role in the research (Zamperini et al., 2015). After a brief survey on basic personal information, the healthcare professionals were asked to narrate, starting from open questions, their experiences with the issues dealt with in this research. The following issues were raised: critical incidents, the emergence of new and worrying symptomatology in noninfected patients such as anxiety disorders and sleeping disorders; resources the healthcare professionals used to face the health emergency; and changes in the healthcare professionals' attitudes and behaviors. The interviews were conducted both in person and through phone calls, based on the availability of the practitioners. The study was approved by the Ethics Committee for Experimentation of the University of Padova (no. 8DD829A1F8F83852FEDB64AAE38A4F79). Before the interviews, informed consent was obtained from all subjects involved in the study.

Results

The thematic analysis identified four themes: critical issues in healthcare, critical incidents, and changes in the attitudes and habits of healthcare practitioners during the pandemic; emotional experiences and primary needs during the emergency; dying during the pandemic and new psychological symptoms in non-infected patients; and resilience and the role of spirituality.

First area: critical issues in healthcare, critical incidents, and changes in the attitudes and habits of healthcare practitioners during the pandemic

The expression "critical issues" refers to the set of general problematic situations (cultural and contextual) that created "critical incidents" that GPs and nurses encountered during their work. Almost all the healthcare providers highlighted a hospital-centered approach to healthcare policy and a disconnection between the national healthcare system and the particular territory. This problem brought out a substantial lack of preparation for managing the pandemic.

Simone, a 67-year-old GP in the province of Brescia, reported:

> The territory as it is organized now, it is crazy. The national healthcare system has a very inadequate organization that is also the result of a total disconnection between hospitals and the territory. This critical issue dramatically emerged with the spread of the pandemic. An unexpected amount of people arrived at the hospital, and healthcare providers were exhausted by all the fatigue.

Alex, a 66-year-old GP in the province of Brescia, stated: "In the most acute phase of the pandemic, patients with severe symptoms, such as high fever, very low oxygen saturation, that is to say, very compromised in their general conditions, were rejected by ambulances as there were no more places." Just as frequent were the critical issues concerning the lack of guidelines and protocols and thus of a shared course of action related to bureaucratic tasks such as the signing of the informed consent or medical prescriptions, to media pressure, and to access to unvalidated and unfiltered information.

The critical issues related to GP–patient communication were almost all linked to telemedicine and, regarding appointments at the clinic, to the lack of protective equipment and knowledge in how to use it. Sandro, a 37-year-old GP in the province of Treviso, said:

> Managing COVID patients on the phone, with patients perceiving themselves as sick while still waiting for [the result of] a test that did not come, exposed on a day-to-day basis to the pressure of daily reports of infected and dead people, that wasn't easy. Managing emotional crises on the phone, all those "I can't stand it anymore," was hard and emotionally fatiguing . . . I could only calm them down on the phone."

The exposure of GPs to the pain of their patients and relatives caused an emotional load that was a constant source of tension and stress. As Alex reported, "The bewildered pain when confronted by the rapid lethal evolution of some patients was felt by families but also by the treating physician." Gino, a 56-year-old GP from the province of Brescia, added:

> We could not treat our patients as we were accustomed; we could not share their pain. That was the worst thing. We found ourselves on the front line. Often, as physicians, we witnessed others' fear, their pain, as we kept seeing sick people—witnessing the pain of patients and their relatives that ends up being reflected in us. As healthcare providers, we were overexposed to the news. We tried to empathize with the pain of others, but it we could also be infected. That was the worst period of my life!.

All the healthcare personnel interviewed, from physicians to nurses, recognized the following as critical issues and causes of critical incidents: the lack of training of personnel in the management of the pandemic and of the acute illness—especially for GPs—and the management of the emotional overload and the lack of psychological support for healthcare practitioners. Simone reported:

> As GPs, we didn't know exactly what it meant to use protective equipment, as you usually wear a white coat. Now, if a patient comes to my clinic because of his throat or because he's got a fever, I don't send him home. I leave him in the laboratory, I get dressed [in personal protective equipment], and I visit them [Personal protective equipment to protect against Covid included surgical masks, gloves, goggles, face shields and gowns]. At the beginning of the emergency, I was not as aware and competent as now, and we had to learn everything as we weren't used to using that device. Now there's more safety, for sure, we don't let our guard down, but we know that, if we work safely, it is quite difficult to be infected.

Second area: emotional experiences and primary needs during the emergency

Veronica, a 45-year-old nurse who worked in a dialysis hospital ward in the province of Venice, reported that her main fear was of being a vehicle of contagion: "I was more afraid for my beloved ones than for me, to be honest. I know what I am facing. Honestly, when I chose it [her profession as a nurse], I didn't know such a thing could happen." Maria, a 50-year-old healthcare nurse in the oncology ward of a hospital in the province of Venice, contracted the virus, and her sense of guilt was added to her fear: "Until I turn negative, I am scared for my beloved ones, because you think of the harm you can do. I already feel guilty for contracting the virus, and now I'm concerned I might infect other people."

Alex reported that one of the critical issues GPs had to face was the management of patients' end of life:

> One characteristic of family medicine is that you have known the patient for a long time. Even 20 or 30 years. Patients and families with whom you can have a very special relationship. Thus, naturally as physicians, we experience a lot of pain when they die. But it is not enough to say that it is painful. It's a strange pain. One of the most characteristic aspects of the disease is that the progression wasn't very intense or violent but rather calm for a few days, then immediately a worsening in their condition, and then an intensification of symptoms that led to the immediate death of the patients. This obviously generated astonishment in both family members and physicians as we didn't expect sudden severe reactions in the patients.

Simone described the route he took every day to go to work. "In the morning I took the car and went from Brescia to the clinic in a provincial town where I work. Then I would return in the evening. In the morning, I saw only ambulances and hearses. Devastating. That journey there to go to work every day was a journey of anguish because I didn't know what I would find." Sonia said: "We were poorly prepared; the virus was new and unknown. It was unclear how the disease would develop. The therapeutic approach was based on antivirals, antibiotics, intubation, cortisone, but we never knew if it was okay or not." Simone also identified a similar issue related to the changes that medicine must undergo to face an emergency: "You can no longer be a doctor as before. The conditions are no longer the same."

Another great need was identified as healthcare professionals with certain areas of expertise, related to professional training in specific areas such as the emergency response to a pandemic. It became important to know a particular disease like never before, both its diagnosis and treatment, but also to have the requisite relational and psychological training. According to Alex:

> Let's say that, from a training point of view, doctors don't have any kind of preparation for this. University education is still mainly hospital-centered and takes little account of these elements because the relationship with the patient is rather episodic. Problem analysis requires skills ranging from clinical aspects, to ethics, spirituality and morality.

In particular, specific skills in the management of end-of-life issues, that is, palliative care, needed to be as a universal requirement for all physicians and, in particular, for GPs. Sandro said, "There was no time. The times and ways of general medicine are not the ones I remember and in which I am most at ease. Palliative care was different before the covid-19 pandemic. During the pandemic period there was no time to provide palliative care. Palliation should be a focus of all doctors, but it is not." Among the various skills that are required, the GP should understand very well how to manage the end of life of patients. As Alex reported:

> First of all, it is necessary to inform the patient of his terminal condition so that he can make decisions related to his life and family. On this point, there are still significant limitations because in order to do so, physicians need to control their emotions that they are probably afraid of or are unable to rationalize; they cannot bring it back to technical tools they use in communication that would make them feel more at ease. The relationship is of two emotions [that of the patient and that of the doctor], and this is sometimes unbearable for physicians, who tend to avoid it."

Third area: dying during the pandemic and new psychological symptoms in non-infected patients

Gino talked about the situation experienced by family members: "They could not hold their hands, or see them, or perform a religious practice or last rites for those who were believers. In specific circumstances, with less severe patients, they were able to see them thanks to technology." As a doctor, Sandro faced the bereavement of the wife of a deceased patient. He reported that, unlike other forms of bereavement, those due to COVID-19 were more difficult. He said: "Knowing that your loved one is sick and not being able to be present creates in the family member, in the person who has an emotional bond, a discomfort because, in most cases, the person could not be there, could not say goodbye."

Alex reported:

> I believe that one of the most touching and painful aspects of the coronavirus experience for family members is the death of their loved ones in isolation, which leads to a re-evaluation of the value and meaning of the signs and rituals in our culture. What the relatives of deceased patients are missing is precisely this last gaze, this last goodbye, as well as the testimony also from the friends and relatives who gather to accompany the body during the ceremony, the funeral, up to the burial in the cemetery. This has always been taken for granted. Now that it is missing, it makes us understand how important these gestures and signs are for our society.

Many people who had not been directly infected, especially young people, experienced this time of the pandemic with extreme concern. This generated the onset of a new symptomatology that mainly affects the psychological sphere, with possible relapses at the somatic level. Doctors have reported an increase in anxiety disorders, panic attacks, and sleep and musculoskeletal disorders. Riccardo, 37, a GP in the province of Brescia, reported: "The increase in anxiety and depressive disorders are the aftermath of the COVID problem." Carla stated: "I think it is difficult to see the beauty. Anxiety, sleep disturbances, panic attacks... a flood of depressed people. This is what I expect. Dynamics will also emerge within couples that are not easy to manage. There have been, for example, forced cohabitations that are at risk of bursting like buboes."

Fourth area: resilience and the role of spirituality

Faith in God and general spirituality were crucial factors for a large proportion of the physicians. Sonia reported: "Being a doctor is not easy, but faith plays an important role in my everyday professional experiences." Sandro added: "I have found comfort in faith. There have been times when even faith has been experienced abnormally." Hope was another resource widely shared by the interviewees. Virginia reported the connection between hope and the relative culture, beyond faith.

> Hope always exists even if there is no personal faith. All of us were born and raised in an area completely steeped in Christian modes of relationship, so anyway that faith is faith, even in our own way, in knowing we are responsible for others, and hope is the last to die, even in the serious cancer patients we follow until the very last moment.

Maria, a nurse who contracted the virus, felt a desire to share her experience with COVID-19 to benefit other COVID-19 patients. "I consider my experience a resource. I

would like to offer myself, once I am permanently cured, to a COVID-19 ward. I wish to support those who are ill, those who have contracted the virus, because I have lived it and I know what it means." Carla said, "I have to say that never before has the group been as instrumental as with this event. Our group of family physicians, in particular, has been a true group." Maria reported:

> My family members have always been there for me and have been brave. My friends have always called me, encouraged me, supported me. Very good. You start to appreciate affection in a different way. Relationships begin to be appreciated in a different way. We make a thousand promises, I will have more time for my relationships, more time for my mother.

Discussion

As discussed in the literature (Alizadeh et al., 2020; Dubey et al., 2020; Kumar et al., 2022; Mesri et al., 2022; Testoni et al., 2021, 2022), our findings confirm that the health professionals who participated in the study suffered from daily stress during the first phases of the pandemic and that spirituality was an important protective factor, a source of well-being and reduction of distress. Numerous studies have analyzed the association between religious/spiritual coping and health in healthcare workers, highlighting the need to consider spirituality an integral part of the care process and of healthcare workers' training (Carey, 2021; Chirico & Nucera, 2020; Mesri et al., 2022; Rogers et al., 2022; Roman et al., 2020).

The participants were severely distressed by their attempts to mediate the needs of patients and their own personal and family needs. All were noticeably unprepared for the emergence of the pandemic. The distancing experiences, such as feelings of abandonment held by patients and family members, caused huge discomfort. Although the literature (Zhou et al., 2020) has described the positive effects of telemedicine, our participants evaluated communications mediated by the Internet as distressing. All of this was embedded in inherently negative opinions regarding the health policy strategies defined as "hospital-centric" that were significantly dysfunctional because of the strong disorganization of services in the various territories and because of institutions' poor capacity for emergency management. During the pandemic, the structural and organizational characteristics of the healthcare system and the psychological and functional demands intrinsic to medical practice highlighted a general unpreparedness that failed to provide adequate responses to the management of the pandemic and the humanization of the contexts of care. Isolation, distancing, and telemedicine emerged as limiting factors, despite the awareness of their necessity to contain contagion.

To compensate for these human and social gaps, all the physicians interviewed reported that while there was more careful listening to patients, albeit limited by the use of technology, they were psychologically vulnerable due to excessive contact with the pain and suffering of patients and family members. The situation contributed to healthcare professionals' experience of feeling a sense of powerlessness and uselessness, related to a sense of guilt and anger. This led to a costly emotional load associated with their work, which exposed them to high stress if not emotional crises. In some cases, the awareness of having to make decisions, even painful ones, for patients can also result in a higher risk of burnout for professionals (Testoni et al., 2022). The coexistence of these emotions led doctors to

an emotional state characterized by pain and exacerbated by constant worrying about contracting the virus and being a vehicle for contagion.

Even though the statements cannot be generalized, our results suggest that healthcare professionals' ability to deal constructively with emotional neutrality may result from human factors and be linked to specific professions, such as the type of training received (Testoni et al., 2018). Within the doctor–patient relationship, communicating and listening are an integral part of care. In the relationship with the patient, next to the scientific knowledge there is relational knowledge that can be shaped in training curricula. Furthermore, it is important to consider that spiritual intelligence is a crucial element of holistic care and an important personal resource in promoting healthcare professionals' well-being, with consequent positive outcomes in clinical practice (Alizadeh et al., 2020; Mesri et al., 2022; Papadopoulos et al., 2021). Understanding and responding to the COVID-19 pandemic has become a public health priority and the responsibility of society and healthcare institutions. Policy-, team-, service-, and system-level interventions are therefore needed to improve well-being and resilience (Dalle Ave & Sulmasy, 2021; Rogers et al., 2022).

Conclusion

Participants showed that they had not fully acquired the requisite skills related to the management of emergencies, the pandemic, the end of life, and the management of personal emotions in their training curricula. For most physicians, the perception of not having done enough was later compensated for by statements from patients and family members, who thanked physicians for their closeness and constant presence. Only in one case did a nurse who contracted the virus state that her doctor was not present to her, and she said this attitude did not support her in her healing process. For many physicians, resorting to spirituality is fundamental in their search for balance and meaning in their work. Spirituality as a complementary intervention in healthcare is a key factor in reducing the psychological effects of traumatic events (Hai et al., 2019) such as the COVID-19 pandemic. Increasing the level of spirituality could be an important strategy to minimize psychological effects, including post-traumatic stress and anxiety (González-Sanguino et al., 2020), even while promoting levels of personal and social well-being.

Research limitations

This exploratory research has limitations. The group of participants was not adequately balanced as the nursing category was underrepresented. Studies on the impact of the COVID-19 pandemic are still fairly new, so information available regarding the full psychosocial impact on healthcare professionals or the best practices to support them during a pandemic is still very much a work in progress.

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Declarations

Ethics approval The studies involving human participants were reviewed and approved by the Ethical Committee for Psychological Research of the University of Padua (no. 8DD829A1F8F83852FEDB64AAE38A4F79.

Consent to participate The participants provided their written informed consent to participate in this study.

Consent for publication All participants gave their consent for the publication of the present article when they granted permission to use the collected data for research purposes by signing the informed consent.

Conflicts of interest/competing interests The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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