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DETERMINING THE PERCEPTIONS OF CONSCIENCE IN NURSES WORKING IN PANDEMIC HOSPITALS

PANDEMİ HASTANELERİNDE ÇALIŞAN HEMŞİRELERDEKİ VİCDAN ALGILARININ BELİRLENMESİ

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Abstract

Objectives: This descriptive study was planned to determine the conscience perceptions of nurses working in pandemic hospitals.
Methods: The study population comprised all nurses working in Sivas Numune Hospital. A personal information form and the Conscience Perception scale were used in the study. The convenience sampling method was applied, the data collection forms were uploaded to the system and a link was created. The forms were thus sent to the nurses for online completion. Informed consent was provided by the nurses and the necessary ethical and official permissions were obtained.
Results: The majority of the nurses participating in the study (95%) were female, married (66.7%), with a university degree (46.9%), and work experience of 21 years or more (35.8%). The conscience perceptions of the female nurses working during the pandemic were determined to be statistically significantly high. The education level of the nurses significantly affected the perception of conscience, with a higher level of conscience perception shown by nurses with a bachelor's degree. The conscience perception scale sub-dimension of the clinic where they worked showed a significant difference in terms of authority. There was a statistically significant increase in the authority sub-dimension of nurses working in the operating room / intensive care unit.
Conclusion: Working conditions and risks affected the conscience perceptions of professional responsibility and sensitivity of nurses who had to remain separated from their families during the COVID-19 pandemic.

Keywords: *Nurse, pandemic, conscience, sense of conscience, pandemic hospital.*

Öz

Amaç: Bu çalışma pandemi hastanelerinde çalışan hemşirelerin bu süreçteki vicdan algılarının belirlenmesi amacıyla tanımlayıcı olarak planlanmıştır.
Yöntem: Araştırmanın evrenini Sivas Numune Hastanesi'nde çalışan tüm hemşireler oluşturmaktadır. Araştırma için Tanıtıcı form ve Vicdan Algısı ölçeği kullanılmıştır. Kolayda örneklem yöntemiyle yapılan çalışmada araştırmanın veri toplama formları sisteme yüklenip link oluşturulduktan sonra online olarak hemşirelere gönderilmiş ve gönüllü hemşirelerden formları doldurmaları istenmiştir. Çalışma için hemşirelerden bilgilendirilmiş onam istenerek, gereken etik ve resmi izinler alınmıştır.
Bulgular: Çalışmaya katılan hemşirelerin çoğunluğunun kadın olduğu (%95), yine büyük çoğunluğunun lisans mezunu olduğu (%46,9), evli (%66,7) ve çalışma yılı 21 yıl ve üzeri olan hemşirelerin (%35,8) sayısının fazla olduğu belirlenmiştir. Ayrıca pandemi sürecinde çalışan kadın hemşirelerin vicdan algılarının istatistiksel olarak anlamlı düzeyde yüksek olduğu, hemşirelerin öğrenim durumunun vicdan algısını anlamlı düzeyde etkilediği ve lisans mezunu hemşirelerin vicdan algılarının daha yüksek olduğu, görev yapılan kliniğin de vicdan algısı ölçeği alt boyutu otorite açısından anlamlı farklılık gösterdiği belirlenmiştir. Ameliyathane/Yoğun bakım çalışanlarının otorite alt boyutunda istatistiksel olarak anlamlı bir yükseklik vardır.
Sonuç: Çalışma şartları, riskler ve aileden uzak kalmak durumunda kalan hemşirelerde, mesleki sorumluluk ve duyarlılık bilinci vicdan algılarını etkilemiştir.

Anahtar Kelimeler: *Hemşire, pandemi, vicdan, vicdan algısı, pandemi hastanesi.*

Introduction

Pandemics differ from infectious epidemics as they are contagious epidemic diseases that spread across very large geographic areas, across continents, or even the entire globe, causing illness and death in humans or animals.[1] The prevalence of pandemics in the general population in many countries, their novel, unpredictable and highly contagious nature, the need for physical distancing and isolation, and the associated high morbidity and mortality rates render traditional coping styles dysfunctional and has led to the development of new technologies. This places an unprecedented burden on healthcare professionals worldwide.[2]

Conscience, which is a mental process, is a multidimensional concept with philosophical, ethical, and moral aspects, affecting attitudes and behaviors in private and professional life. Conscience is seen as an internal guide, reminding people what to do and creating a moral and ethical awareness.[3] The word conscience is of Latin origin; "Conscientia" refers to a moral understanding that guides a person's behavior related to right and wrong.[4]

Conscience is an important concept for healthcare team members who serve the public directly and often work with vulnerable communities. Healthcare professionals have to balance the demands and emerging needs of patients, their relatives, and their own colleagues. When these factors cannot be balanced, contradictions or conflicts of conscience may arise in patient-related practices.[5]

While trying to meet the current demands of the health system with the nurse workforce, which is currently in a difficult situation, and while maintaining the care service, the difficulties experienced are exacerbated by the process of infection, and the need for self and patient protection.[6] Nurses not only experience an increased workload, but also try to adapt to new protocols and a very "new normal".[7] In many institutions, nurses have to work with end-of-life care patients more frequently, as well as trying to adapt to a situation in which they witness the person's health deteriorating faster than they are accustomed to.[2] During a pandemic, the fact that patient relatives cannot be with the patient during critical periods or at the end of life due to isolation rules causes nurses to try to provide this support and/or to structure the remote interaction between patients and their relatives. However, the use of masks, glasses, visors and protective clothing due to protective measures prevents the use of facial expressions, gestures and even the nurse's voice, all of which are important tools in establishing therapeutic interaction with patients, and limits nurse-patient interaction.[6]

It is known that nurses are constantly faced with ethical dilemmas due to external factors such as theoretical forces, physicians, drug demands and medical treatment practices, and pressures from patients and their relatives. The lack of professional authority makes it difficult for nurses to make decisions of conscience in practice.[8] In some cases, it has been observed that they experience stress of conscience due to fear of stigma or the fact that patients do not have the right to object to their wishes and/or doctor's request. Ignoring the inner voice and ethical virtue in nursing practice leads to self-affirmation, emotional pain and uncertainty, and ultimately to stress of conscience.[9] It has been determined that stress of conscience in nursing causes dissatisfaction and burnout, increases the intention to leave, and negatively affects practices aimed at providing high-quality patient care.[6]

Conscience is an important concept for healthcare team members who directly serve people and often work with vulnerable communities. Healthcare professionals have to balance the demands of patients, their relatives and their colleagues with the emerging needs.[10] When these factors cannot be balanced, conflicts of conscience may arise or conflicts in practices related to the patient. In addition, problems of conscience may negatively affect the service and health of the patient.[11]

Conscience is one of the concepts of nursing ethics, which is fundamental for nursing, improves ethical nursing care and positively affects nursing practices.[12] It has been shown that nurses who listen to their conscience have fewer conflicts on issues of conscience and can provide high-quality care in practice.

The Ministry of Health defined pandemic hospitals as 'an inpatient health institution especially appointed and organized for the treatment of those carrying the disease that caused the pandemic'. There is no study in the literature on the perception of conscience in healthcare workers in Turkey, which should be considered a very important concept especially during the COVID-19 pandemic. However, Aksoy et al. conducted the validity and reliability study of the nurses' perception of conscience scale and thereby contributed to this research.[13]

The COVID-19 pandemic affected healthcare professionals throughout the world and they are still experiencing intense stress due to the pandemic. Nurses strive to balance care in order to do the right thing, taking into account patient rights, professional obligations and their own conscience. Although working in a hospital in times of infectious disease is satisfying with the knowledge that one is caring for humanity, witnessing the illness and terminal stages of patients and the distress of relatives negatively affects the psychology of the employees. This process, which affects the burden and perceptions of conscience of nurses came to be considered normal during the COVID-19 pandemic.

A pandemic can change the conscience and ethical perspective of healthcare professionals. Therefore, the aim of this study was to determine the conscience perceptions of nurses working in pandemic hospitals during this period.

Materials and Methods

Design and purpose of the study

The population of this descriptive study comprised nurses working in Sivas Numune Hospital, which was designated as a Pandemic Hospital in the province of Sivas. After obtaining the necessary ethical and official permissions, 81 nurses were contacted online and asked to complete the forms without using any sample selection method.

During the pandemic, the number of volunteers to participate in the study seemed to be low as only nurses were evaluated and those with chronic diseases, healthcare workers with children, and pregnant nurses on maternity leave were excluded.

There was only one pandemic hospital in the province where the study was conducted. The study included only the nurses working in the pandemic hospital, and thus other hospitals were not taken into consideration.

The study was conducted between June 2021 and December 2021. All procedures were in accordance with the principles of the Declaration of Helsinki. The average time to complete the forms was 5 minutes. The data were then uploaded to the Statistical Package for the Social Sciences (SPSS) 23.0 program and statistical analyses were made.

Data Collection Forms

Sociodemographic Form: This form was prepared in line with the literature and consisted of 7 questions to obtain information about the demographic characteristics of the nurses and the clinic in which they worked.

Conscience Perception Scale: This scale was developed in 2007 by Vera Dahlqvist and Sture Eriksson. Validity, and reliability studies of the scale for use on nurses in Turkey were conducted in 2019 Aksoy et al. A 13-item form of the Conscience Perception Scale was used. Each item is scored from 1 point (No, I totally disagree) to 6 points (Yes, I totally agree). There is no reverse item scoring on the scale, which has two factors of Sensitivity (items 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13), and Authority (Items 9, 11). The total score ranges from 13 to 78, with higher scores indicating a high sense of conscience.

Ethical Approval

Before starting the study, the necessary permission was obtained from the Ethics Committee of Sivas Cumhuriyet University with the decision dated 07.06.2021-45682. After ethical approval, official permission was obtained to conduct the study at Sivas Numune Hospital.

Evaluation of Data

Data were analyzed statistically using SPSS 23.0 software. Conformity of the data to normal distribution was checked with the Kolmogorov-Smirnov test. Continuous variables were stated as mean ± standard deviation (SD) values and categorical data as number (n) and percentage (%). In the comparisons of two independent groups, the Independent Samples t-test was used for data that met parametric conditions, and comparisons of more than two groups were applied with the F test (ANOVA). A value of $p<0.05$ was accepted as statistically significant.

Results

The data were evaluated by comparing the frequency distributions of the nurses' sociodemographic characteristics, scale score averages, and demographic characteristics. The sociodemographic characteristics of the nurses participating in the study are shown in Table 1.

The majority of the nurses were female (n=77, 95%), married (66.7%), with a university degree (n=38, 46.9%), and work experience of 21 years or more.

The mean age of the nurses was 37.4±7.61, and the burden of conscience scale score was determined as 65.38±11.86 (Table 2). The conscience perceptions of nurses working in pandemic hospitals during the pandemic were determined to be higher than the average. The mean scores in the sensitivity and authority sub-dimensions were high.

The relationships between the scale and sub-dimension scores and some sociodemographic characteristics of the nurses are shown in Table 3.

A statistically significant relationship was determined between the gender of nurses and the burden of conscience ($p<0.05$). Female nurses were seen to have higher conscience perceptions than male nurses, and higher scores in the sensitivity sub-dimension. In the sub-dimension of authority, females had higher scores than males, but the difference was not statistically significant.

No significant relationship was determined between the marital status of the nurses and the perception of conscience and the sub-dimensions. The nurses with a university degree were determined to have a significantly higher perception of conscience and there was a similar significant relationship in the sensitivity sub-dimension. No significant relationship was found between the level of education and the sub-dimension of authority.

Table 1. Frequency Distribution of Some Socio- Demographical Characteristics of Nurses

Features		n	%
Gender	Female	77	95.1
	Male	4	4.9
Education Level	High school	12	14.8
	Associate degree	5	6.2
	License	38	46.9
	Graduate	26	32.1
Marital status	Married	54	66.7
	Single	27	33.3
Working Year	0-5 Years	13	15.1
	6-10 Years	12	14.8
	11-20 Years	27	33.3
	21 and over	29	35.8
Who do you live with	Alone	10	12.3
	Spouse-Child	49	60.5
	With family	22	27.2
Service/ Clinics	Internal Units	16	19.8
	Surgical Units	12	14.8
	ICU/ Operating Room	22	27.2
	Quality-Training Units	18	22.2
	Polyclinics	13	16.0

Table 2. Ages of the Nurses and the Average Scores of the Burden of Conscience Scale and its Sub-Dimensions

Features	Min	Max	Mean±SD
Age	23	53	37.49±7.61
Burden of Conscience Scale Score	13.00	78.00	65.38±11.86
Sensitivity Sub-Dimension	11.00	66.00	56.50±9.84
Authority Sub-Dimension	2.00	12.00	8.87±2.72

The clinic in which the nurses worked was seen to have a statistically significant effect on both the perception of conscience, and on the sensitivity and authority sub-dimensions ($p<0.05$). The perception of conscience was significantly higher ($p<0.05$), and the sensitivity and authority sub-dimension scores were significantly higher in nurses working in specialized units such as intensive care units (ICU) and operating rooms. The nurses working in internal clinics had significantly lower conscience perceptions and sensitivity/authority sub-dimension scores.

Discussion

This study was conducted to determine the burden of conscience of nurses working during the COVID-19 pandemic. The results showed that the majority of the nurses were female, which was compatible with other studies as the nursing profession is a female-dominated profession all over the world. [14-16] During the pandemic, it was observed that

Table 3. Comparison of some sociodemographic characteristics and conscience perception scale dimensions

Socio- Demographical Features		Mean ± SD		
		Burden of Conscience	Sensitivity	Authority
Gender	Female	65.94±10.53	56.93 ± 8.59	9.01 ± 2.62
	Male	54.50±27.79	48.25 ± 24.83	6.25 ± 3.68
p		0.001*	0.000*	0.79
Marital status	Married	65.14 ± 11.52	52.62 ± 9.47	8.51 ± 2.75
	Single	65.85 ± 12.72	56.25 ± 10.71	9.59 ± 2.56
p		0.350	0.364	0.482
Education Level	High school	65.25 ± 13.17	55.83 ± 11.66	9.41 ± 2.06
	Associate degree	59.20 ± 26.03	51.60 ± 22.74	7.60 ± 3.84
	Licence	67.42 ± 8.46	58.15 ± 6.68	9.26 ± 2.60
	Graduate	63.65 ± 11.92	55.34 ± 9.52	8.30 ± 2.90
p		0.001*	0.004*	0.346
Clinic in charge	Internal medicine	63.81 ± 10.87	55.56 ± 9.62	8.25 ± 2.17
	Surgical	66.41 ± 10.43	58.08 ± 7.54	8.33 ± 3.17
	MD/Operating Room	76.66 ± 2.30	64.66 ± 2.30	12.00 ± 0.0
	Quality & Education	66.77 ± 10.50	57.16 ± 8.65	9.61 ± 2.37
	Policlinic	65.61 ± 16.43	57.07 ± 14.32	8.53 ± 3.20
p		0.003*	0.015*	0.005*

the female-dominated occupational group worked with serious devotion.[17] When marital status was examined, there was observed to be a significant difference in the burden of conscience of the female group, who were mostly married nurses and had different responsibilities at home. The conscience and sensitivity sub-dimension scores of female nurses were statistically significantly higher than those of male nurses. Although there has been no previous study in Turkey of nurses' perception of conscience, similar results have been reported in literature from studies conducted in other countries.[10,11] In terms of gender roles, as it is still mothers who take care of children, the pandemic was more difficult for working mothers.[6,18] This shows that gender significantly affects the perception of conscience and sensitivity.

Nursing is a professional group with a wide range of education levels, with nurses having studied at high school, or having obtained an associate degree, bachelor's or master's degree. In the literature, it is seen that the number of nurses with undergraduate degrees is high in studies related to nursing.[2] Although the current study shows parallelism with this information, the number of nurses with undergraduate degrees, almost half of the nurses in the study (46.9%), was higher than the other levels of education. Similar results have been previously reported.[19] Considering the relationship between the perception of conscience and the education level, it was determined that the education level had a statistically significant effect on both the perception of conscience and sensitivity *($p<0.05$)*. The perception of conscience of the nurses with undergraduate degrees was found to be significantly higher than that of the others, and the sensitivity sub-dimension was similarly higher. While the perception of conscience increases as the level of education increases, the reason for the decrease in both the burden of conscience and the sensitivity score of postgraduate nurses can be attributed to the fact that most of the nurses who receive postgraduate education complete postgraduate studies outside the field. While undergraduate education affects the perception of conscience in nursing, the perceptions of conscience of nurses with a master's degree in different fields were not affected at a statistically significant level.

Another significant result in this study is that the clinics where the nurses worked had a statistically significant effect on their conscience perceptions *($p<0.05$)*. Nurses working in specialized areas such as intensive care / operating room had statistically significantly higher scores for both conscience perceptions, and the sensitivity and authority sub-dimensions *($p<0.05$*). The increase in the number of intensive care unit patients and the poor prognosis of the patients, especially during the pandemic, can be considered to have affected the conscience perceptions of the nurses working in these areas. In addition, the postponement of leaving the intensive care and operating room during the pandemic, having to keep watch continuously and the deterioration of family communication could also be seen as factors affecting the perceptions of conscience. The fact that patient care and treatment was given with clearer protocols under authority in ICU might have have caused the authority score to be higher. As a result of the study, it was determined that health workers experienced significant problems during the pandemic,[20] and

their perceptions of conscience were also significantly affected. Gender, educational status and the clinics in which the nurses were working in pandemic hospitals were determined to affect the burden of conscience. Many studies have shown that the mental health of nurses was adversely affected during the pandemic.[21,22]

A further evaluation of the conscience perceptions of nurses after the pandemic would be appropriate to be able to make comparisons and to alleviate the psychological burdens of nurses. Moreover, there is a need for planning different clinic rotations for nurses to ensure the active participation of nurses working in other units, and flexible planning should be implemented, taking into consideration the working conditions and social roles of female nurses. It can also be recommended that training programs are organized to improve the conscience perception of nurses.

Limitations

This research could be re-applied to a larger sample over a longer time period.

Further comparative studies could examine nurses working and not working in a pandemic hospital. While the pandemic period was suitable for descriptive research, there is a need for interventional research. The study could be repeated with the provision of educational support to strengthen the nurses' perception of conscience.

Conflict of Interest

The authors have no conflict of interests to declare.

The study was not funded by any institution/organization.

Nurses participating in the study were informed verbally and in writing.

The study has not been presented elsewhere.

Sivas Cumhuriyet University Ethics Committee, numbered E-60263016-050.06.04-45682, dated 07.06.2021.

Author Contributions

FH: Concept; FH: Design; YB: Audit; PC: Resources; YB: Materials; YB: Data Collection and/or Processing; FH: Analysis and/or Interpretation; PC: Literature Review; FH: Writing; PC: Critical Review

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