


Lived Experiences Among Critically Ill and Near-Death Survivors Relating to the COVID-19 Infection: A Phenomenological Study

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Abstract

Introduction: The COVID-19 pandemic has resulted in severe illnesses worldwide. Around 655.5 million cases were having been confirmed, including 6.6 million deaths. The extreme cases experienced near death in the intensive care unit (ICU). This study explored the survivors' experience of being near death while critically ill with the infection. **Methodology:** A descriptive phenomenological study was employed. Data were collected through in-depth interviews with 14 participants from Northeastern Thailand. Content analysis was applied by using Creswell's strategy. **Results:** Four themes emerged: (a) anxiety and fear of dying alone, (b) environmental chaos, (c) using Thai Buddhist teaching in coping, and (d) returning from the brink of death. Moreover, the patients felt great gratitude and were grateful to the health care team. **Discussion:** Traumas experienced by patients in the ICU included physical and psychological distress, coping strategies, and an understanding of cultural awareness. **Conclusion:** Psychological and culturally congruent care should be implemented for patients in the ICU.

Keywords

COVID-19, critical illness, near-death, phenomenological study, Thailand

Introduction

The COVID-19 pandemic has caused severe health problems and tragic deaths worldwide. There were 655.5 million cases having been confirmed, including 6.6 million deaths (World Health Organization, 2022). In Thailand, with a total population of 66.1 million (The Bureau of Registration Administration, 2022), approximately 4.6 million people have been confirmed to be infected with novel coronavirus (COVID-19) cases with 32,771 deaths (Worldometer, 2022). There were 46,047 cases in Nakhon Ratchasima province and 37,892 cases in Ubon Ratchathani province, Northeastern region of Thailand (Ministry of Public Health of Thailand, 2022). Symptoms of patients with COVID-19 ranged from mild symptoms to extremely severe symptoms. The extremely severe symptoms included fever, chills, difficulty breathing, low oxygen saturation, chest pain, acute respiratory distress syndrome (ARDS), and so on. Advanced age and co-morbidities were associated with an increased mortality rate (Peterfi et al., 2022). Patients aged 60 years and above had more than three times higher chance of contracting COVID-19-associated ARDS (Gujski et al., 2022). In the

previous study, 54.9% were classified as severely ill, 65.3% were diagnosed with ARDS, 32.4% were admitted to the ICU, and 26% died (Machado-Alba et al., 2021). The survivors experienced positive and negative effects (Norouzadeh et al., 2021). The positive effects included patients' great hope of recovering from the severe pandemic. This is because they have confidence and trust in the health care team and in good medical care. In addition, the patients have received moral support from the health care team, dramatically boosting their psychological morale. On the contrary, the negative effects included death anxiety, a great fear of dying, loneliness, sleep disturbance, sadness when their symptom conditions worsened, and so on (Hengyotmark & Kusoom, 2022). The rate of death anxiety in patients with COVID-19 was

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very high (Firouzkouhi et al., 2022). Moreover, they experienced depression, posttraumatic stress symptoms, and sleep problems (Gezginci et al., 2022; Nochaiwong et al., 2021). Problems were associated with cognitive complaints, emotional problems, and delusions of ICU memories (Martins et al., 2022). The patients experienced suffering between individual and family. After being hospitalized, patients described living with uncertainty, sadness, fear of death, and concerns about family. In this context, spirituality and religiosity have emerged as important coping mechanisms to overcome mental and physical health problems and promote positive emotions, which could strengthen the immune system and minimize suffering (Bhaskar & Mishra, 2019, as cited in de Diego-Cordero et al., 2023). Previous studies found the impacts of COVID-19 on the provision of spiritual care, spiritual needs during the pandemic, and religion (Domaradzki, 2022). The patients requesting spiritual care were more likely to be distressed (Schultz et al., 2018). The culturally competent nurse can assess patient care needs in partnership with the patient based on cultural similarities and differences that might influence the effectiveness of jointly agreed care plans (Leininger as cited by Christley, 2014). In addition, health care providers should respect clients' beliefs, values, and expressions and establish a partnership between the health care team and clients to ensure safe, beneficent, and culturally congruent care (McFarland & Eipperle, 2008, as cited by Wehbe-Alamah, 2020). Therefore, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) included a considerably more significant, more deadly risk of hospitalization and intensive care. There was a shortage of beds in Thailand, even for severe cases of situational dilemmas (Hengyotmark & Kusoom, 2022). The severe cases have suffered not only physical but also mental and spiritual distress. Coping strategies were used.

Currently, few qualitative studies on COVID-19 explore the experiences of survivors of COVID-19 in the ICU. The researchers are teachers of nursing students and work in critical care nursing. We intend to explore how critically ill patients experience near death with COVID-19 infection. This qualitative study can explore the life experiences, interpretations, and perceptions of people with COVID-19. Their experiences are important to nurses and the multidisciplinary team to understand how to improve the quality of care for these patients.

Research Question

What are the survivors' experiences of being near death while critically ill in the ICU with the COVID-19 infection?

Study Aim

This study aimed to explore the survivors' experiences of being near death while critically ill in the ICU with the COVID-19 infection.

Method

Study Design

This qualitative study was based on a descriptive phenomenological approach, which provides an understanding of a phenomenon as experienced by several individuals. The phenomenological study is a design of inquiry from philosophy and psychology to lived experiences for several individuals about a phenomenon described by participants (Creswell & Creswell, 2018). It can be used to provide insights into a patient's experiences of being near death and critically ill with COVID-19 infection while in the ICU. In addition, it could be very effective in expanding knowledge on better care for ICU patients and improving preparations for future outbreaks.

Setting

The setting was the participants' home from six communities in two provinces: eight participants from Nakhon Ratchasima province and six participants from Ubon Ratchathani province, Northeastern, Thailand. In this context, social, cultural, and religious beliefs are similar.

Sampling

Purposive and snowball sampling techniques were used. Inclusion criteria were people aged ≥ 18 years and discharged from the ICU within 1 and 6 months and with no symptoms of cough, dyspnea, shortness of breath, palpitation, no cognitive impairment, and ability to communicate in in-depth interviews. Moreover, they were willing to provide rich information about their experiences of being near death while critically ill with the COVID-19 infection. Exclusion criteria included cough, tiredness, shortness of breath, palpitation, cognitive impairment, eyes, and hearing impairment. After the strict screening, 17 were eligible. In a phenomenological study, data were saturated when gathering new data no longer sparks new insights or reveals new properties (Creswell & Creswell, 2018). Therefore, a sample size of 14 participants was used.

Instruments

In-depth interviews included face-to-face, semistructured individual interviews, open-ended dialogue, field notes, reflective notes, and audio recording tape. Some of the questions were along the lines of "How is your health?"; "Could you please tell me about your illness?"; "What are your experiences of being near death while critically ill with the COVID-19 infection?" and so on.

Data Collection

After the Institutional Review Board (IRB) approval, we contacted the hospital administrators for permission from

Table 1. Demographic Characteristics.

Participant number and gender	Age (years)	ICU stay (days)	O ₂ therapy	Educational level	Employment status	Religion	Comorbidity
1. Male	65	30	MV	Univ	Retirement	Buddhist	DM, HT, Gout
2. Male	56	28	MV	Univ	Employed	Christian	HT, neuritis
3. Pregnant female	30	20	HFNC	HS	Employed	Buddhist	Pregnant 7 m
4. Female	75	14	HFNC	ES	Unemployed	Buddhist	CKD, DM
5. Female	47	30	MV	ES	House wife	Buddhist	Overweight, DM, HT
6. Female	73	15	HFNC	Univ	Retirement	Buddhist	Ca colon
7. Monk male	65	20	HFNC	Univ	Retirement	Buddhist	Asthma
8. Male	67	24	MV	HS	Employed	Buddhist	CKD, HT
9. Female	62	21	HFNC	ES	Unemployed	Buddhist	HT, DM
10. Male	72	25	HFNC	ES	Unemployed	Buddhist	HD, HT
11. Female	57	22	MV	ES	House wife	Buddhist	CKD
12. Female	45	25	MV	ES	Employed	Buddhist	DM, HT, overweight
13. Male	49	15	MV	Dipl	Employed	Buddhist	None
14. Female	76	28	HFNC	Univ	Retirement	Buddhist	DM, HT, stroke, overweight

Note. MV = mechanical ventilator; HFNC = high flow nasal cannula oxygen; ES = elementary school; HS = high school; Univ = university; HT = hypertension; DM = diabetes mellitus; HD = heart disease; Ca = cancer; CKD = chronic kidney disease.

participants to speak with them. Before the interview, the study's objective, the interview's time, and the procedure of answering the questions were explained to the key informants. Informed consent was obtained from them beforehand (e.g., survivors and family members). The setting was the key informant's home for the onsite interview and via cellphone in the second and third times. During the interviews, family members were with the participants. Qualitative data was collected by observation and face-to-face in-depth interviews guided by the research questions. Moreover, reflexive notes were revised prior to each interview. Probing questions and closing instructions were incorporated (Creswell & Creswell, 2018). Observations were focused on key informants and the environment. All interviews were recorded with the key informant's permission. Each interview took approximately 30 to 45 minutes and was conducted twice to three times until the data information was completed. Researchers always possess a perspective of reality (Creswell & Creswell, 2018). The study was conducted between September and November 2022.

Data Analysis

The interviews were recorded and transcribed to be subsequently analyzed using multiple five steps. The data were analyzed following Creswell and Creswell's strategy (Creswell & Creswell, 2018). The five multiple steps included (a) organizing and preparing the data for analysis, involving transcribing interviews, typing up field notes, (b) reading through all data several times to obtain an overall feeling for them, identifying significant phases or sentences that pertained directly to the experience, (c) coding the data/organizing the data by tagging areas and assigning code labels of the image, compiling all codes for the image on a separate sheet, reducing the codes to potential themes, (d) interrelating themes/descriptions, using

the coding process to generate description, and (e) interpreting the meaning of themes/descriptions of the phenomenology (Creswell & Creswell, 2018).

Rigor and Trustworthiness

Four criteria were considered: credibility, dependability, confirmability, and transferability, accumulatively contributing to trustworthiness (Lincoln & Guba, 1985, as cited in Creswell, 2013). Rapport and trust were established, and prolonged periods were spent conducting fieldwork. The interviewer carefully avoided using ideas to lead participants to express their experiences. The reflexive data, checked by the research team, were carefully collected to make them meet the confirmability criteria. Dependability was enhanced through the debriefing of the data collection and analysis, which included the input of two external consultants in nursing and a Buddhist monk. Moreover, transcripts were taken back to participants for comments (Creswell, 2009; Creswell & Creswell, 2018). There were no new data during validation.

Results

1. Characterization of the study participants

The phenomenological study's demographic characteristics comprised 14 participants, including eight females and six males aged between 30 and 76, with a mean age of 59. The ICU length of stay was between 14 to 30 days (mean 22 days). Most participants had one co-morbidity or more, including one pregnant woman (Table 1).

2. From the data analysis, four core themes emerged with 14 subthemes. The four core themes included (a) anxiety and fear of dying alone, (b) environmental

Table 2. The Analysis of Data Revealing 4 Themes With 14 Subthemes.

Themes	Subthemes
1. Anxiety and fear of dying alone	1. Worry about onset and suffering from severe symptoms 2. Fear of helplessness 3. Fear of lonely death 4. Unlucky and stigma 5. Worry concerning shortage of doctors and nurses
2. Environmental chaos	6. Noise of other patients, sleep disturbance 7. ICU delusion, nightmare, and normal dream 8. Loss of communication, and social isolation
3. Using Thai Buddhist teaching in the coping	9. Buddhist beliefs, Thai Buddhist religious practices 10. Positive thinking
4. Returning from the brink of death	11. Prolonged stay in the ICU 12. Progression of treatments 13. New life/miracle of life 14. Gratitude to health care team

chaos, (c) using Thai Buddhist teaching in coping, and (d) returning from the brink of death (Table 2).

The following are cases presented along with participants' quotes of account.

Anxiety and Fear of Dying Alone

The seven participants were put on mechanical ventilators, and seven were given high-flow cannula oxygen (HFNC). All participants described their distressing symptoms: dyspnea, low oxygen, rapid heartbeat, uneasiness, and fear of more severe symptoms. Most were at high risk of co-morbidity such as diabetes mellitus (DM), hypertension, heart disease, cancer, overweight, and older adults. They experienced fear and anxiety of death, fear of lonely death, helplessness, and hopelessness due to severe illness. Ten said they were unlucky, sad, in despair, and stigmatized. They experienced fear of a shortage of hospital beds, physicians, and lack of nurses. Ten of them felt stigmatization from the COVID-19 illness, which they felt might result in their lonely death.

I felt my heart beating very fast and was short of breath. I thought, will I survive? I kept checking myself every minute. Was there anything wrong? If it got worse, I felt I would not survive. I wondered if there were enough nurses to help me. I felt extremely sad and despaired that I would die alone. (Male 72 y)

I had to be on the machine with the tube in my throat. I was afraid because of the shortage of doctors and nurses, and I didn't want to die being helpless. (Male 62 y)

I knew that being infected with COVID was scary and that people might try to avoid me for fear that they should catch the disease. And I felt I would die alone. (Female 76 y, Male 49 y)

A 7-month pregnant woman explained that she had been crying and feared dying a lonely death and expressed anxiety to her family.

I was crying alone; how unlucky I was, and I felt terrified of dying a lonely death. I felt worried and anxious about my new baby and two more kids at home. I had not talked to my husband and feared I would die alone. The main thing I wanted was to talk with my husband and my kids. (Pregnant female 30 y)

Environmental Chaos

The ICU is a depressing place, and the unit is chaotic. The environment in ICU is stressful and irritating, and the light is very bright. The patients were delirious and agitated. In three cases, they had nightmares and ICU delusion. The other four cases had dreams in general. The participants had given accounts of their experiences as follows:

I stayed in the ICU for 30 days. (Female 47 y and Male 65 y)

I was confused, and I had a false belief. I had seen many things on the ICU clock's face: a colorful portrait, a long-haired woman raising her eyebrow, smiling, and calling me. There was even hair wrapping around the clock. This went on for 28 days, and it made me sleepless. After I went back home, I never had strange dreams again. (Female 75 y)

I didn't know how to vent my problems with someone. I felt an unknown person shaking my bed. I couldn't sleep until 4 a.m. It was just like I was in jail, but I understood that it was necessary to be isolated. (Female, 56 y).

It was very noisy in the ICU. There were 12 occupied beds there. All patients were critical cases. Many patients died on the bed next to mine. (Male 67 y)

Using Thai Buddhist Teaching in the Coping

Thirteen participants are Buddhist. They said they used spiritual, religious belief, and positive thinking strategies to help them cope with their adverse situations. They prayed to the Lord Buddha and did transcendental meditation (Samadhi) and Anapanasati (mindfulness of breathing). They tried to

find something holy they respected and could hold on to strengthen their mind and positive thinking. They practiced Samadhi to relax both body and mind, which helped them sleep. One participant prayed to his deceased parents. These strategies helped them heal and get back on their feet again.

For me, I have taught the Dhamma of Buddha's teaching. Buddhism teaches us that birth, old age, illness, and death are natural lifecycle parts. I do not worry about death. Although I was exhausted, I stayed in the here and now. I had time to pray and to be mindful. I practiced Samadhi and Anapanasti to assist me in healing my body, mind, and spirit. The practice helped me sleep well. (Monk male, 65 y)

I followed the nurse's advice by listening to Dhamma via YouTube on my cellphone, and I prayed on Buddha's holiness every day, then I felt more relaxed and slept well. (Female 45 y)

I prayed for support from my parents who have passed away, and I carried a small picture of them with me during my hospitalization. (Female 75 y)

One patient prayed to a ten-baht-coin with an image of King Rama IX of Thailand.

I prayed to King Rama IX for support to help me feel safe and secure. (Female 47 y)

Returning From the Brink of Death

All participants described the various treatments and support the health care team gave them, which resulted in their complete recovery. They were in the ICU for either 14 or 30 days. They felt as though they had returned from the brink of death. They related that a team of physicians and nurses helped them recover. They felt so grateful to the health care team.

I had fever, tiredness, palpitations, and felt like I was going to die. Then, I was given oxygen. It was a miracle, and I felt much better. I had a new life coming back from the brink of death by a healthcare team. (Male 49 y)

The nurses are my angels. The three nurses helped me change my lying-down position and looked after me very well. I was getting better every single day. They gave me the feeling of a new life. (Female 62 y)

I felt sorry for the nurses wearing PPE for 3-4 hours each time in the ICU. They were behind my recovery. (Male 49 y; Female 73y)

Discussion

Most participants had co-morbidity, and seven older adult participants had co-morbidity and were vulnerable. Advanced age and co-morbidities were associated with an increased mortality rate (Peterfi et al., 2022). Patients aged 60 years and above had more than three times higher chance of

contracting COVID-19-associated ARDS (Gujski et al., 2022). Dyspnea and dementia were associated with a greater risk of death for older adults from the COVID-19 infection (Damayanthi et al., 2021).

Anxiety and Fear of Dying Alone

A previous study found that patients admitted for a long term to the ICU would develop death anxiety, referring to a great fear of dying, loneliness, sleep disturbance, sadness when their symptoms worsened, etc. (Hengyotmark & Kusoom, 2022).

The rate of death anxiety in patients with COVID-19 was very high, and they suffered from a high level of death anxiety (Firouzkouhi et al., 2022). The primary cause of this suffering was dyspnea or shortness of breath and deficient oxygen levels (Hodkinson et al., 2021). Because of these severe conditions, including admission into the ICU, ventilators, and HFNC were crucial and needed (Ozguç et al., 2021). It was reported that hospitalization in the ICU and intubation were also sources of death anxiety in patients with COVID-19. The participants would experience a difficult time during isolation due to physical problems, loneliness, and separation from their families (Galehdar et al., 2020). A highly significant positive correlation existed between their loneliness and death anxiety (Buyukbayram et al., 2022). Moreover, the patients with COVID-19 experienced psychological distress, which increased six-fold from 9.6% to 72.5% (Thomas et al., 2021). They experienced great psychological distress, death anxiety, stigmatization, and sleep pattern disturbance during the acute phase of the disease or even long after recovery (Toulabi et al., 2021). As a result, the patients had depression, anxiety, and a loss of self-esteem. Health care providers spent less time with them, which impacted the patient's safety, with an eightfold difference in adverse events relating to supportive care failures (Chochinov et al., 2020). He et al. (2020) suggested that the worries about discrimination against COVID-19 patients must be addressed culturally and emotionally as a priority by the health care team when treating them with COVID-19. Bruns et al. (2020) strongly suggested that timely and appropriate public health interventions addressing the cultural impact and risk of stigmatization, proper screening, and treatment of serious illness were necessary.

Environmental Chaos

Participants expressed that the ICU was an isolated unit with a chaotic environment. They had sleeping problems due to stress and were irritated by the very bright light in the unit. Moreover, they witnessed other patients sometimes being delirious, agitated, noisy, and dead.

A previous study found that they had experienced the death of other patients in the ICU (Hengyotmark & Kusoom, 2022). There was a phenomenon relating to the unknown prognosis of the disease and environmental stressors (Gezginci et al.,

2022), which suggested that the environmental stressors in the ICU were high and the patients were at risk from anxiety and depression. Bulbuloglu et al. (2022) suggested that the environmental stressors created an emotionally exhausting negative perception in the patient. As a result, most patients experienced a difficult time during their isolation due to physical problems, loneliness, and separation from their families (Galehdar et al., 2020). Several studies suggested that the environmental stressors in the ICU were high, and the patients were at risk of anxiety and depression, posttraumatic stress symptoms, and sleep problems (Gezginci et al., 2022; Nochaiwong et al., 2021).

Using Thai Buddhist Teaching in the Coping

Participants used spiritual coping strategies such as Buddhist mindfulness techniques, transcendence meditation (Samadhi), Anapanasati, and positive thinking. Many patients found relief from their depression by using Buddhist mindfulness meditation. Mindfulness-based interventions have effectively reduced anxiety and depression symptom severity in a broad range of treatment-seeking individuals (Hofmann & Gomez, 2017). Previous studies found that Buddhist teachings about mindfulness positively affected mental health during the COVID-19 pandemic: happiness, mental peace, mental energy, and mental stability (Channuwong & Ruksat, 2022). For this reason, perhaps Buddhist mindfulness meditation should be included in treating depression (Turakitwanakan et al., 2016). Thai Buddhist teachings present helpful ways to cope with stress by calming the mind to be free from stress and suffering to insight meditation, such as breathing meditation or Anapanasati (Channuwong et al., 2018). Previous studies found the impact of COVID-19 on the provision of spiritual care and spiritual needs during the pandemic and the effects of COVID-19 on religion (Domaradzki, 2022). The patients requesting spiritual care were more likely to be in spiritual distress (Schultz et al., 2018). The culturally competent nurse can assess patient care needs in partnership with the patient based on cultural similarities and differences that might influence the effectiveness of jointly agreed care plans (Leininger as cited in Christley, 2014). In addition, health care providers should respect clients' beliefs, values, and expressions and establish a partnership between the health care team and clients to ensure safe, beneficent, and culturally congruent care (McFarland & Eipperle, 2008, as cited in Wehbe-Alamah, 2020). Therefore, health care providers must listen to patients, assess their beliefs and values, and implement care decisions that avoid offensive practices (Nursing, 1996, as cited by Busher Betancourt, 2015).

Returning From the Brink of Death

According to their accounts, the participants had been critically ill and had felt close to death. However, the treatments

were effective, resulting in the patient's successful recovery. The patients had been cultivating patience, and from that came a strengthening of mind, utilizing positive thinking concerning their illness. They had faith and trust in the care of the health care team, which helped them survive and gave them a sense of renewal or re-birth. Hodkinson et al. (2021) found that the participants' experience of severe COVID-19 through a difficult and terrifying ordeal was mitigated by faith-based beliefs and the presence and care of the health care team. After this experience, they were grateful to the health care team, especially the nurses. Intensive care units are described as "the frontline of a war" against the COVID-19 disease (Selman et al., 2020). On the contrary, previous studies found that nurses were more likely to report posttraumatic stress disorder (PTSD) symptoms (33%) and psychological distress (23%) than physicians (5% for both) and other health disciplines professionals (Mehta et al., 2022).

Limitations and Recommendations

This study was conducted by using only 14 participants. It may not represent a broader area in Thailand. Therefore, further studies should be conducted in other regions of Thailand. In addition, quantitative research and effective interventions for patients with COVID illness in the ICU are needed.

Conclusions and Implications

The results can be summarized into four themes: anxiety and fear of dying alone, environmental chaos, using Thai Buddhist teaching in coping and returning from the brink of death. Spiritual strategies using belief and Thai Buddhist religious practices were employed. Health care professionals should perform efficiently caring for patients in the ICU environment. Finally, religious beliefs and cultural congruence should be implemented in nursing care for patients in the ICU.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Ethical Approval

This study was approved by the Institutional Review Board of Bangkokthonburi University, Thailand, Approval No. 9/2022. All research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2008 (<https://www.wma.net/wp-content/uploads/2018/07/>

DoHOct2008.pdf). The researchers explained the purpose and method of the research through a preinterview. All participants were informed and assured of confidentiality, and they knew and understood that they could withdraw from the study at any time without negative consequences. Participants who agreed to participate in the study had to provide written informed consent first. We assigned a participant number to replace the participants' names on the transcripts. All electronic data were kept in password-protected files on secure computers and only accessed by the researchers. The reflexive notes and audio recordings were stored separately in a locked drawer.

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Supplemental Material

Supplemental material for this article is available online.

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