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Modern-Day Heroes Amidst the Pandemic: Health Risk, Life Satisfaction and Death Anxiety of Front-liners

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Abstract

COVID-19 pandemic has brought the nation's capital healthcare system into its critical mass, leaving the front-liners at significant risk while sacrificing their lives to fight against the COVID-19. This study aimed to determine the relationship between the front-liners' profile, health risk, life satisfaction, and death anxiety. This study utilized a quantitative, descriptive-correlational design and a purposive sampling technique that involved 100 front-line healthcare workers from Tayabas, Quezon. Instruments were researcher-made questionnaires, validated by experts, and underwent pilot testing. These include the personal information sheet, health risk questionnaire, physical and mental health risk, and the death anxiety questionnaire. To find the relationship between variables, Pearson's correlation coefficient was used. Results indicated that relationship between death anxiety and the respondents' profile was not significant except for the years of employment, which has a significant inverse relationship. Meanwhile, both the physical health risk and death anxiety and mental health risk and death anxiety have significant relationships. However, life satisfaction and death anxiety has a significant inverse relationship. This study suggests providing intervention to prevent death anxiety by improving the front-liners' physical, mental health, and life satisfaction.

Keywords: *COVID-19, pandemic, health risk, life satisfaction, death anxiety, front-liners*

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1. Introduction

Despite having the longest lockdown globally, the cases of COVID-19 continue to rise in the Philippines. Based on the World Health Organization statistical record, as of December 01 2020, there were 432,925 confirmed cases in the Philippines, with 8,418 deaths. Presently, people have been living with a threat of death and uncertainties. To control and prevent the virus from spreading, President Rodrigo Duterte places the entire Luzon under an enhanced community quarantine; which implies a force of total lockdown and suspension of activities and business at school. "Work from home was implemented within the Executive branch to avoid further socialization, except for the PNP, AFP, PCG, health, and emergency front-line services, border control, and other critical services that ensure a skeletal workforce." (Official Gazette, 2020). Hence, during this pandemic, front-liners have a significant role in fighting against COVID-19; that is why they are hailed as the country's modern-day heroes. As the healthcare workers quip *"to the call of duty while struggling with fear and anxiety"* (Kinder, 2020).

Front-liners do not feel like being celebrated as heroes, but as soldiers, they have no choice but to follow the order in waging war. They argued that the nation's capital healthcare system had reached a critical mass. As a consequence, they were putting their physical and mental health at risk. Aside from constant exposure to the virus and death, they have experienced burnouts, under pressure, stress, insomnia, denial, anguish, and fear. (Rana et al., 2020). While dealing with the country's healthcare system and their health, the life satisfaction of the front-liners has become challenging. They felt fulfilled in their work as they serve the nation. They also have experienced a noble purpose in life. De Pedraza et al. (2020) describes that those healthy people, with a paid job, having a great relationship with their family and friends, and suffering less from loneliness report high satisfaction in life. On the other hand, the pandemic outbreak threatens human life satisfaction. Other front-liners feel less satisfied because they want to achieve more in life. Nurses plan to work abroad because of the insufficient salary they received (Salud, 2020). They do not feel fulfilled in their work because they feel threatened by this ongoing pandemic; they also feel less satisfied as they deserve a better salary, a healthcare system, and benefits.

As the pandemic reports high cases of mortality, death anxiety gradually arises too. It reflected this idea in laboratory findings during the Ebola virus outbreak that happened in the past, demonstrating that virus outbreaks had increased the accessibility of death-related thoughts

(Arrowood et al. 2017). Moreover, life satisfaction was not only threatened but also could influence death anxiety. If one can find meaning or purpose in life, death anxiety is believed to show less effect. If they have not and cannot achieve any meaningful activity in their lives, the likelihood of death anxiety has developed. Healthcare workers deal with their mortality and the inevitability of more death.

While there have been empirical attempts to examine death anxiety, little is known to explore healthcare workers' death anxiety amidst the pandemic. So far, most studies are focused on healthcare workers' depression and anxiety during this pandemic. This study focused on the less recognized type of anxiety or fear: death. Likewise, in the Philippines, there are limited studies regarding death as it is always a taboo, bad omen, and should not be discussed at all (M.B. Lifestyle, 2020). It often causes an uncomfortable amount of silence in Filipino society. It is one of the sensitive topics that people tend to suppress, and as a result, people who developed death anxiety could not undergo proper intervention. By refusing to acknowledge death inevitability, people neglect the purpose of life and live unfulfilled lives (Grimwald, 2015). Hence, this study argues that front-liners may have developed death anxiety, and acknowledging it is necessary to provide proper intervention. Furthermore, this study intended to understand and explore the health risk and life satisfaction that could influence death anxiety and its relationship. Thus, it may contribute to psychology and health as it provides new and more learning information that investigates the current situation that the front-liners have been experiencing amidst the pandemic. It is hoping to address the issues in the healthcare system in the Philippines.

2. Literature review

2.1. Health Risk

Sabillo (2020) points out that despite the risk caused by COVID-19, millions of medical front-liners around the world continue to go to work while risking their lives to save and protect others. However, in the Philippines COVID-19 cases hit almost 13,000 healthcare workers. This accounted for 20% of the overall number of COVID-19 cases. As of December 2020, 76 healthcare workers have died. Likewise, a similar observation by Liu et al. (2020), the cases of COVID-19 have infected 30 healthcare workers, including 20 doctors and eight nurses in a hospital. Of these, 26 had a mild infection, and 4 had a severe infection, and they were all

exposed to the virus. Not only the Philippines report the cases of front-liners, Ng et al. (2020) from Singapore recorded the outcome of 41 healthcare workers exposed to a COVID-19 pneumonia patient before a diagnosis of COVID. Despite the exposure, none of the 41 healthcare workers developed COVID-19 because all the healthcare workers were wearing surgical and N-95 masks.

In Wuhan, China, Kang et al. (2020) described that healthcare workers have been experiencing excessive pressure and facing a high risk of infection and insufficient protective gear from contamination of the virus. They also experienced overwork, frustration, discrimination, having patients with negative emotions and attitudes, exhaustion, isolation, and lack of contact with their families. This difficult situation is causing mental health problems such as stress, insomnia, anxiety, depressive symptoms, denial, anger, and fear. Moreover, these mental health problems affect the healthcare worker's attention, understanding, and decision-making ability, which might hinder the fight against COVID-19 and could have a lasting effect on their overall well-being.

In the study conducted by Torrentira (2020), qualitative data expressed the struggles of medical front-liners in the Philippines and found medical front-liners have experienced emotional stress and despair, caused by the uncertainties when the crisis will end. The surge of patients and the vast amount of suspected cases exhaust them. Leaving medical front-liners with no choice but to care for patients, they also have developed anxiety and paranoia due to carrying the weight of saving lives at their own expense. Furthermore, front-liners have developed a fear of spreading the virus to their families. Nicomedes et al. (2020) discussed that Filipino front-liners have experienced fear of spread, which includes the fear of acquiring the COVID-19 virus and spreading it at work and to family members as a result of continued reporting to work. They worry about their family; and one of their primary concerns is contracting the virus, which could infect their parents or any other old member of their family.

There is also a tremendous amount of health risks because of a lack of health personnel, medical supplies, and facilities. Amnesty International (2021) discussed that healthcare access is still in a critical state. Healthcare workers have warned that hospitals are becoming overcrowded because of a lack of beds and health personnel. Health care workers also deal with unpaid benefits and a shortage of medical-grade personal protective equipment (PPE). Emerlynne Gil, Amnesty International's Deputy Regional Director, mentioned that it is saddening to see large

numbers of ambulances and private vehicles lining the streets outside hospitals. Inside, there are people with COVID-19 and their families, some of whom are dying while waiting for medical attention. Meanwhile, other patients have transferred to medical facilities hundreds of kilometers away, only to be turned away because of a lack of healthcare capacity.

2.2. Life Satisfaction

The healthy people, with a paid job, having a great relationship with their family and friends and suffering less from loneliness report high satisfaction in life (De Pedraza et al. 2020). Consequently, Sadang (2020) concluded that although nurses' nature of work is challenging and risky, it brought them honor, privilege, and self-satisfaction. Most nurses acknowledged their worth as healthcare workers, despite the risks posed in their duties and responsibilities. They also stated that it was out of a passion for serving their countrymen, especially in this pandemic. However, Magsambol (2020) expressed that nurse's salary is never enough to cover their expenses, especially when supporting their family. Although the Salary Standardization Law has been signed, increasing the take-home pay of nurses, a ₱ 1,500 ($29.72) increase is insignificant for someone raising and supporting a family. Lalu (2021) stated that health workers seeking pay hikes say nothing has changed since the pandemic started. The government allowed a wage increase for health workers by reclassifying their salary grades, but this did little to compensate for the rising day-to-day costs. Health workers' salaries are no longer adequate to meet their family's healthcare critical basic needs.

2.3. Death Anxiety

Doctors scored much lower death anxiety than nurses. As reasoned by Jonasen and O'Beirne (2015), doctors spend less time with their patients; therefore, they have less death anxiety than nurses who are arguably more "hands-on." A hospice nurse usually spends more time with the patient, providing help with a constant, emotionally supportive presence, not just with medical and personal treatment. A nurse is also one of the healthcare workers most likely present when a patient takes his or her final breath. Thus, these factors could increase the death anxiety of a healthcare worker.

An article "*Death anxiety among emergency care workers*" explains why emergency nurses, paramedics, and other urgent care personnel can experience death anxiety. It shows that emergency and unscheduled healthcare personnel such as emergency nurses and paramedics

were continually reminded of death and mortality because of their work, making them more vulnerable to death anxiety. Even though emergency nurses and paramedics may not be aware of death anxiety, they have been exposed to it in their everyday practices (Brady, 2015). Similarly, Newton-John et al. (2020) explain that COVID-19 presents different challenges to humans due to the constant reminders of mortality and death. The ever-present image of death, daily updates about the transmission of the virus, and other cues to death, such as face masks, suggested that we are practically living in an ongoing and global mortality salience study. Accordingly, Saeed and Bokharey (2016) found in a study that life satisfaction was inversely related to death anxiety, thus life satisfaction has a negative relationship with death anxiety. In addition, it was reported that high death anxiety was associated with less life satisfaction in comparison with people who had low death anxiety.

2.4. Theoretical framework

The terror management theory by Greenberg et al. (1986) is the leading psychological framework for explaining the effect of fear of death on human behavior. It focused on the role of awareness of death. Terror management theory also addressed the fact that when one is reminded of their mortality, they tend to increase one's sense of responsibility and defense of worldview, self-esteem, and relationships with others. Furthermore, when these aspects of life are confronted, people are more vulnerable to death-related thoughts, which leads to death anxiety.

In times of global pandemic, terror management theory describes people living with the threat of death from a pandemic. They also experience worldwide challenges, mental health, and hindrances to career goals. In addition, being far away from family members and friends who constantly validate one's significance is currently far more difficult to deal with death anxiety. This pandemic has raised awareness of everyone's vulnerability. As a result, it has magnified death anxiety. A recent study found that anxiety and fear of individuals regarding one's physical health and well-being have increased during this pandemic (Jungmann & Witthöft, 2020).

With the presumption that death anxiety increases because of an awareness of death, the current study was anchored on the terror management theory. It explains that as individuals become more aware of death's inevitability, they will instinctively try to suppress it out of fear; otherwise, they will confront it, leading to more vulnerable death-related thoughts. Aside from this, terror management theory explained that it is hard for the front-liners to manage death anxiety terrors during this pandemic. In defense, they thought about the sense of purpose in their

work. In their line of work, they are constantly reminded of death and their mortality, it triggers their death-related thoughts. Thus, without having proper intervention in handling this condition, they are at the utmost significant risk of developing death anxiety.

Another theory is the Psychosocial theory by Erik Erikson (1982). The last stage in the theory is "Integrity vs. Despair," describes that when people grow older, they will progress through a sequence of stages related to a crisis. The theory encompasses the idea that once individuals reach the latest stage of life, they reach the level entitled "ego integrity." In this stage, people contemplate their accomplishments and can develop integrity if they perceive themselves as living a prosperous and contented life. Hence, when a person can discover meaning or purpose in their life, they have achieved the stage of integrity. When a person has acquired this level of ego integrity, it reports feeling less influenced by death anxiety. In opposition, when individuals view their lives as a series of failed and wasted opportunities, they do not achieve the ego integrity stage. Thus, they feel a sense of despair and will exhibit a potent influence on death anxiety.

The attitude concerning death is demonstrated through the last stage of the perspective of psychosocial theory. This is the stage of reflection wherein one can either build a high life satisfaction and accomplishment, resulting in approaching death with peace and acceptance. Contrarily, they develop a sense of despair and sorrow over missed opportunities and wasted time, leading to fear of dying and approaching death with dread. Thus, life satisfaction was analyzed using psychosocial theory as COVID-19 also challenges the life satisfaction of front-liners.

3. Methodology

3.1. Research Design

This study utilized the quantitative research method that describes a systematic investigation of phenomena by gathering quantifiable data and performing statistical methods and treatment. It also employed the descriptive-correlational research design to determine the possible relationship of the independent variable (the profile of the respondents, health risk, and life satisfaction) with the dependent variable (death anxiety).

3.2. Sample and Sampling Technique

A purposive sampling technique was utilized through a prepared criterion intended for front-liners who are healthcare workers from Tayabas, Quezon. Purposive sampling is a non-probability sampling based on the characteristics of a population and the purpose of the study. Hence, front-liners who works in a healthcare setting are selected as they are the one who is directly fighting against COVID-19.

There were 100 healthcare workers as participants of the study. Among 100 respondents, the majority of the respondents were nurses (56%), 21 – 33 years old (71%), female (75%), single (77%), and Roman Catholic (86%) with 1 to 10 years of employment (87%).

3.3. Research Instrument

All the instruments used in conducting the study were researcher-made questionnaires, validated by experts, and underwent pilot testing. The questionnaires were pilot-tested through an online survey to 20 healthcare workers who are not actual respondents. Using Cronbach alpha, the reliability was tested. The research instrument has four parts: the personal information sheet; the health risk questionnaire, which comprises 2 factors, the physical and mental health risk with a 0.889 reliability score (*good reliability)*; the life satisfaction questionnaire with 0.852 reliability score (*good reliability)*; and the death anxiety questionnaire with 0.918 reliability score (*excellent reliability)*. For interpreting the score, a 4-point Likert scale was used.

3.4. Data Gathering Procedure

The survey was administered through an online platform. The respondents were reached through their emails and Facebook messengers to seek voluntary participation on the survey. Informed consent was attached to the Google form survey including the purpose of the study and a declaration that results were to be used for educational purposes only. The first phase of the questionnaire administration was on the personal network. The Google form link was sent to the consented participants. In order to reach the quota sample, the second phase – snowball approach – was implemented. The respondents were asked to refer their colleagues to become respondents. The study treated the gathered data confidentially.

3.5 Data Analysis

The data were processed using the Statistical Package for the Social Sciences (SPSS). Statistical treatments used were frequency, percentage, mean, and Pearson's correlation coefficient. The Pearson's correlation coefficient was used to measure the correlation to determine the magnitude and direction of the relationship between the profile of the respondent and death anxiety, the relationship between health risk and death anxiety, and the relationship between life satisfaction and death anxiety.

4. Findings and Discussion

Table 1

The Front-liners' Physical Health Risk

	Indicators	M	SD	VI
1.	Our hospital/workplace experiences a shortage of PPE.	2.79	0.71	Agree
2.	I feel unsafe with the extended work shift hour and duration I have to work.	2.98	0.92	Agree
3.	Our hospital/workplace experience a shortage of testing kits and medical supply.	2.72	0.74	Agree
4.	Due to the lack of facilities, rooms, and beds to cater to probable COVID-19 patients, I feel I'm at risk of being infected by the virus.	3.3	0.75	Strongly Agree
5.	Our hospital experience a lack of Manpower such as Medical Personnel and Medical professionals.	3.36	0.79	Strongly Agree
6.	Our hospital/workplace experiences challenges in providing pre-cautionary safety measures.	2.99	0.80	Agree
7.	We encounter problems and challenges in enforcing social distancing in our workplace.	2.94	0.81	Agree
8.	Our hospital/workplace provides inadequate rest hours.	2.67	0.84	Agree
9.	We encounter problems with dishonesty and the non-cooperation of patients in giving information.	3.5	0.70	Strongly Agree
10.	I have been continuously exposing to a probable and increasing number of COVID-19 patients.	3.31	0.77	Strongly Agree
	Overall	**3.06**	**0.43**	**Agree**

Legend: 4.00-3.26 = Strongly Agree; 3.25-2.51 = Agree; 2.50-1.76 = Disagree; 1.75-1.00 = Strongly Disagree

Table 1 shows the level of health risk in terms of physical health risk of the respondents. Indicator 9 has the highest mean score of 3.5 and a standard deviation of 0.70, which means a *very high level* of physical health risk. The result shows that the respondents *strongly agree* that they encounter dishonesty and non-cooperation of patients in giving information. Thus, it implies

that dishonesty and non-cooperation of patients could lead to a significant physical health risk factor to the front-liners. This coincides with Torrentira (2020) on the struggles of medical front-liners with the dishonesty and non-cooperation of patients during interviews upon checking them. Because out of fear of being admitted, some of the patients do not reveal correct information upon the interview. In some cases, patients do not cooperate with medical front-liners. This is a crucial part because, when the patient is found positive, contract tracing must need to be undertaken. With the dishonesty and non-cooperation, it is hard for them to establish correct intervention to address the situation because they should know accurate information about the patient.

Meanwhile, indicator 8 has the lowest mean score of 2.67 and a standard deviation of 0.84, which means a *high level* of physical health risk. According to the result, the respondents *agree* they experience inadequate rest hours. Even though it has the lowest mean score, the level of physical health risk was *high*. Hence, it signified that front-liners comprise their physical health due to the physical health risk of having inadequate rest hours. Moreover, with an overall weighted mean of 3.06 and a standard deviation equivalent of 0.43, the respondents have a *high level* of health risk in terms of physical health risk. Thus, it implies that the respondents *agree* on the following: the problem with dishonesty and non-cooperation of patients, lack of manpower and facilities, been continuously exposed to the virus, challenges in providing pre-cautionary safety measures, feeling unsafe with the extended work shift, inadequate rest works and the shortage of PPE and medical supplies.

This experience was due to the nature of the work of the front-liners that could lead to risking their lives, especially their physical health. As Shaukat et al. (2020) concluded that healthcare workers are at risk for developing physical and mental health consequences due to their role in providing care to patients with COVID-19.

Table 2 presents the level of health risk in terms of the mental health risk of the respondents. Indicator 6 has the lowest mean score of 1.69 and a standard deviation of 0.99, which means a *low level* of mental health risk. The result shows that the respondents *disagree* on engaging in substance use, such as drinking and smoking. Even though front-liners face immense stress at work, their coping mechanism does not involve engaging in substance use, such as drinking alcohol and smoking. For front-liners, engaging in substance use could only lead to more health risk factors. Since they are healthcare workers, they know the adverse effect of

engaging in substance use. As cited in an article *"Substance Abuse in Health Care Professionals"* (2015), healthcare workers are highly known to be the champion of health habits and lead healthier lifestyles than the general population with lower rates of smoking and higher rates of exercise.

Table 2

The Front-liners' Mental Health Risk

	Indicators	M	SD	VI
1.	Because of the pandemic crisis, I have experienced trouble falling or staying asleep	2.8	0.86	Agree
2.	I worry that I may carry the COVID-19 virus when I get home and infect my loved ones.	3.83	0.45	Strongly Agree
3.	Due to the feeling of under pressure, I have experienced mental burnout.	3.08	0.86	Agree
4.	I feel despair and down by the uncertainties when this pandemic would end.	3.12	0.79	Agree
5.	I experienced breathing difficulties such as rapid heartbeat and shortness of breath during and after work.	2.31	0.98	Disagree
6.	I engage in substance use (drinking alcohol, smoking)	1.69	0.99	Disagree
7.	With the continuously increasing number of COVID-19 cases, I over think or am not able to control worrying about what worst thing could happen to me during this pandemic.	3.03	0.87	Agree
8.	I have faced stigma from my community because of my profession.	2.75	0.86	Agree
9.	With an overwhelming workload, I feel exhausted at the end of the day.	3.27	0.78	Strongly Agree
10.	I feel anguish with the inadequate support from the government.	3.58	0.68	Strongly Agree
Overall		2.95	0.43	Agree

Legend: 4.00-3.26 = Strongly Agree; 3.25-2.51 = Agree; 2.50-1.76 = Disagree; 1.75-1.00 = Strongly Disagree

The front-liners also experienced mental health risks because of the possibility of exposure and contact with the virus. They fear for their family's health security and constantly worrying about their safety as well. Thus, these experiences lead to anxiety and over thinking.

Indicator 2 has the highest mean score of 3.83 and a standard deviation of 0.45, which means a *very high level* of mental health risk. It denotes that the respondents *strongly agree* that they worry they may carry the COVID-19 virus when they get home and infect their loved ones. Hence, most front-line nurses experienced fear of COVID-19. They were also afraid of spreading the virus to their family because of the highly contagious nature of the COVID-19 virus (Villar et al., 2021). Similar to the explanation of Nicomedes et al. (2020), Filipino front-liners had experienced fear of spread, which includes the fear of acquiring the COVID-19 virus and spreading it at work and to family members as a result of continued reporting to work.

An overall weighted mean of 2.95 and a standard deviation equivalent of 0.43 reveal that the respondents have a *high level* of health risk in terms of mental health risk. Thus, it implies that the respondents *agree* on the following symptoms of psychological distress, depression, anxiety, burnouts, insomnia, exhaustion, pressure anguish, and stigma. This supports the discussion of Kang et al. (2020) on the fight against COVID-19 in Wuhan, China.

Table 3

The Front-liners' Level of Life Satisfaction

	Indicators	M	SD	VI
1.	I have gotten important things I want in life.	2.72	0.74	Agree
2.	I am contented with what I have become as a person.	2.86	0.73	Agree
3.	I have a sense of fulfilment and honor in my nature of work.	3.22	0.60	Agree
4.	I spent adequate and meaningful quality time with my family.	2.54	0.87	Agree
5.	My salary is more than enough to cover all expenses.	1.54	0.73	Strongly Disagree
6.	I am healthy and have a healthy lifestyle.	2.69	0.80	Agree
7.	I see my purpose in life.	2.93	0.83	Agree
8.	I receive unconditional love and acceptance from my loved ones.	3.4	0.75	Strongly Agree
9.	I view myself as leading a successful life.	3.23	0.78	Agree
10.	My friends and I are happy with each other's company.	3.39	0.71	Strongly Agree
	Overall	**2.85**	**0.49**	**Agree**

Legend: 4.00-3.26 = Strongly Agree; 3.25-2.51 = Agree; 2.50-1.76 = Disagree; 1.75-1.00 = Strongly Disagree

Table 3 is the level of life satisfaction of the respondents. Indicator 5 has the lowest mean score of 1.54 and a standard deviation of 0.73, which means *very low level* of life satisfaction. The results show that the respondents *strongly disagree* on the satisfaction concerning their salary. This is similar to the observation of Magsambol (2020) that nurse salary is never enough to cover their expenses, especially when supporting their family. As narrated by Lulu (2021) health workers seeking pay hikes but nothing has changed since the pandemic started.

Despite strong dissatisfaction with the respondents' salary, it shows that the respondents were very satisfied when it comes to receiving unconditional love and acceptance from their loved ones. Indicator 8 has the highest mean score of 3.4 and a standard deviation of 0.75, which means *very high level* of life satisfaction. It denote that the respondents *strongly agree* that they received unconditional love and acceptance from their loved ones. This is congruent with

Papathanasiou et al. (2015) that mental health employees experience higher levels of general satisfaction and specifically higher satisfaction from family roles.

With an overall weighted mean of 2.85 and a standard deviation equivalent of 0.71, the respondents have *high level* of life satisfaction. Thus it implies that the respondents *agree* and have *high level* of life satisfaction with what they have attained and accomplished in life. The respondents also had a sense of fulfilment with their nature of work, view themselves as leading a successful life, and see their purpose in life. More so, they were satisfied in relationships with their loved ones and friends. This manifests the findings of De Pedraza et al. (2020) that healthy people, with a paid job, having a great relationship with their family and friends and suffering less from loneliness report high satisfaction in life. Similarly, the findings of Sadang (2020) clearly explain the nurses' nature of work as challenging and risky but brings honor, privilege, and self-satisfaction.

Table 4

The Front-liners' Level of Death Anxiety

	Indicators	M	SD	VI
1.	I fear dying in a painful death.	3.34	0.84	Strongly Agree
2.	I'm anxious that I might die as well in this time of the pandemic.	3.02	0.90	Agree
3.	It scares me that I might die before I've completed all of my goals.	3.22	0.85	Agree
4.	I have trouble falling asleep when thinking about death.	2.6	0.94	Agree
5.	I worry about my death expenses will be a burden to my family.	3.05	0.91	Agree
6.	I worry that my loved ones won't be by my side when I am dying.	3.13	0.96	Agree
7.	I'm afraid of people in my family dying during this pandemic.	3.72	0.51	Strongly Agree
8.	The thought of leaving my loved ones behind when I die scares me	3.53	0.69	Strongly Agree
9.	I worry that I might die when I get infected by the virus.	3.14	0.91	Agree
10.	I am afraid of dying from a life-threatening disease.	3.48	0.69	Strongly Agree
	Overall	**3.22**	**0.53**	**Agree**

Legend: 4.00-3.26 = Strongly Agree; 3.25-2.51 = Agree; 2.50-1.76 = Disagree; 1.75-1.00 = Strongly Disagree

Presented in Table 4 is the level of death anxiety of the respondents. Indicator 7 has the highest mean score of 3.72 and a standard deviation of 0.51, which means a *very high* level of death anxiety. It denote that the respondents *strongly agree* they were afraid of people in their families dying during this pandemic. This pandemic has brought immense fear and anxiety, especially to the healthcare workers. The respondents are afraid they might be the carrier of the

virus and could pass it on to their families. They do not just worry about themselves, but also for their families. This same scenario is described in the study of Gawrych et al. (2020). Moreover, this pandemic brought uncertainty and death anxiety to everyone. It implies that people are living with the threat of death. The respondents become more aware of their mortality. Thus, this death anxiety made the respondents have experience trouble falling asleep when thinking about death.

Indicator 4 has the lowest mean score of 2.6 and a standard deviation of 0.94, which means a *high level* of death anxiety. Although it has the lowest mean score, it still has a high level of death anxiety. The result shows that the respondents *agree* they have experienced trouble falling asleep when thinking about death.

With an overall weighted mean of 3.22 and a standard deviation equivalent of 0.53, the respondents have a *high level* of death anxiety. Thus, with the nature of the work of the respondent and constant reminders of death cues, the respondents *agree* on the fear of the dying process, dying without completing their goals, and dying of their loved ones. The explanation of Brady (2015) fits the results of the study. Even though emergency nurses and paramedics may not be aware of death anxiety, they have been exposed to it in their everyday practices.

Table 5

The Relationship between Front-liners' Demographic Profile and Death Anxiety

Profile	r-value	P-value	Interpretation	Decision
Age	-0.134	0.184	Not Significant	Accept H_o
Sex	0.023	0.819	Not Significant	Accept H_o
Civil Status	-0.079	0.437	Not Significant	Accept H_o
Religion	-0.009	0.927	Not Significant	Accept H_o
Occupation	0.036	0.723	Not Significant	Accept H_o
Years of Employment	-0.237	0.018	Significant	Reject H_o

Legend: P value < 0.05 – Relationship; P value > 0.05 - No relationship; P value = 0.001-0.002 High Relationship

Table 5 presents the relationship between demographic profile and death anxiety of the respondents. The result shows that all the factors have a *low correlation* in which it implies that age, sex, civil status, religion, occupation, and years of employment have little influence on the death anxiety of the respondents. However, the years of employment is significant which means that the sample results reflect something true of the population. In terms of years of employment, the p-value equaled to 0.018, which is less than 0.05, and the r-value equals -0.237, which is *negative*. Thus reject H_o. Hence, there is a *significant inverse relationship* and a *low correlation*

between years of employment and death anxiety of the respondents. This implies that the respondents who have more years of employment are most unlikely to experience death anxiety than those who have fewer years of employment. Moreover, as the years of employment increase, the front-liners already know how to handle death anxiety. This is the exact opposite of the study of Nia et al. (2016) which showed that less work experience for nurses was significantly more inclined to feel fear of death and avoidance.

Table 6

The Relationship between Front-liners' Health Risk and Death Anxiety

Source of Variables	r-value	P-value	Interpretation	Decision
Physical Health Risk and Death Anxiety	0.198	0.048	Significant	Reject H_o
Mental Health Risk and Death Anxiety	0.346	0.000	Significant	Reject H_o

Legend: P value < 0.05 – Relationship; P value > 0.05 - No relationship; P value = 0.001-0.002 High Relationship

Table 6 exhibits the relationship between health risk and death anxiety of the respondents. Physical health risk has a p-value of 0.048, which is less than 0.05, and an r-value of 0.198, which is positive. Thus reject H_o. Hence, there is a *significant positive relationship* and a *low correlation* between the physical health risk and death anxiety. In terms of the mental health risk, it has a p-value of 0.000, which is less than 0.05, and an r-value of 0.346, which is positive. Thus, reject H_o. Hence, there is a *significant positive relationship* and a *moderate correlation* between mental health risk and death anxiety. This result implies that both physical and mental health risks could influence death anxiety. Thus, it also connotes that as respondents become more exposed to physical and mental health risks they are most likely to experience death anxiety. The results affirm the study Nia et al. (2016) that nurses and other healthcare workers experience death anxiety as a negative affective state that is induced by mortality salience.

Table 7

The Relationship between Front-liners' Life Satisfaction and Death Anxiety

Source of Variables	r-value	P-value	Interpretation	Decision
Life Satisfaction and Death Anxiety	-0.226	0.023	Significant	Reject H_o

Legend: P value < 0.05 – Relationship; P value > 0.05 - No relationship; P value = 0.001-0.002 High Relationship

Table 7 presents the relationship between life satisfaction and death anxiety of the respondents. Life satisfaction has a p-value of 0.023, which is less than 0.05, and r-value that is -0.226, which is *negative*. Thus, reject Ho. Hence, there is a *significant inverse relationshi*p and a *low correlation* between life satisfaction and death anxiety of the respondents. This implies that the two variables are exactly the opposite, which means respondents who have high life satisfaction are more unlikely to experience death anxiety than those who have less life satisfaction or vice versa. This is the exact findings of Saeed and Bokharey (2016) that life satisfaction was inversely related to death anxiety.

5. Conclusion

This study showed that the level of front-liners' physical and mental health risk is both *high*. Similarly, the level of life satisfaction is *high*, and the level of death anxiety is also *high*. The tests of relationships proved *no significant relationship* between the level of death anxiety and the profile of the respondents in terms of age, sex, civil status, religion, and occupation thus *null hypothesis was accepted*. Meanwhile, there is a *significant inverse relationship* between the years of employment and death anxiety, thus, *reject the null hypothesis*. There is a *significant relationship* between the level of death anxiety and the level of physical health risk, thus, *reject the null hypothesis*. There is also *significant relationship* between the level of death anxiety and the level of mental health risk, thus, *reject the null hypothesis*. Finally, there is a *significant inverse relationship* between the level of life satisfaction and the level of death anxiety.

The healthcare systems and management need to recognize the need to impose policies and provisions for further improvement of healthcare facilities, personal protective equipment acquisition, and monitoring front-liners wellness to lessen exposure to health risks and improve productivity and life satisfaction. For this, the support of the local and national government by providing a better healthcare system and benefits is expected. With the alarming results of the study, necessary intervention is a must to further support the front-liners.

Since the study is limited to 100 respondents and a survey technique, a further study is necessary to evaluate the actual experience of the front-liners. The personal narratives of the front-liners can support the numerical results in this study.

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