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IMPACT OF DEATH ANXIETY ON HEALTH-RELATED QUALITY OF LIFE AMONG HEALTHCARE PROFESSIONALS: MODERATING EFFECT OF SELF-EFFICACY

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Death anxiety, health-related quality of life, self-efficacy, healthcare professionals, moderation, psychological well-being, cross-sectional study.

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Abstract

Background: *Death anxiety is a common psychological concern among healthcare professionals because of frequent exposure to critically ill patients, terminal illnesses, and patient deaths. Persistent death anxiety may adversely affect health-related quality of life (HRQoL). Self-efficacy has been recognized as a psychological resource that may improve coping with occupational stress and enhance overall well-being.*

Aim: *To determine the impact of death anxiety on health-related quality of life among healthcare professionals and to examine the moderating effect of self-efficacy.*

Methods: *A quantitative descriptive cross-sectional study was conducted among 250 healthcare professionals working in selected tertiary care hospitals. Participants were recruited using a convenience sampling technique. Data were collected using a structured questionnaire comprising demographic information, the Death Anxiety Scale, the General Self-Efficacy Scale, and a Health-Related Quality of Life scale. Data were analyzed using SPSS version 27. Descriptive statistics, Pearson's correlation, linear regression, and PROCESS macro moderation analysis were performed. Statistical significance was set at* $p < .05$.

Results: *Participants reported moderate levels of death anxiety and moderate to high levels of self-efficacy and health-related quality of life. Death anxiety significantly predicted health-related quality of life* ($R^2 = .454$, $\beta = .674$, $p < .001$). *Self-efficacy showed a significant direct association with health-related quality of life. The interaction between death anxiety and self-efficacy was not statistically significant* ($\beta = -.232$, $p = .221$), *indicating that self-efficacy did not moderate the relationship.*

Conclusion: *Death anxiety significantly influenced health-related quality of life among healthcare professionals. Self-efficacy improved health-related quality of life directly but did not moderate the relationship between death anxiety and health-related quality of life. Healthcare organizations should implement psychological support and resilience-building interventions to promote healthcare professionals' well-being.*

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Introduction

Death anxiety is a multidimensional, psychological phenomenon defined as fear, apprehension or emotional distress regarding one's own death or the process of dying. Health-related quality of life (HRQoL) is a person's own assessment of their physical, psychological, social and functional health status which is affected by their health. Self-efficacy refers to an individual's self-confidence or confidence in their ability to execute and coordinate activities needed to control a situation in a successful manner. Every healthcare worker comes across critically ill patients, unexpected deaths, traumatic emergencies, and end-of-life care in his or her practice. Mortality exposure leads to mental strain and has a bearing on work performance, emotional states and lifestyle. Self-efficacy is a psychological asset that is known to facilitate the adaptation of health professionals to work stress and their psychological resilience in challenging clinical settings (Bandura, 2021; Qayyum et al., 2023).

Healthcare workers in most parts of the globe are concerned with death anxiety as an important issue in occupational health. Nearly one in three healthcare workers is suffering from clinically significant psychological distress due to repeated exposure to death, traumatic events and experiences of suffering, according to global estimates. Research post-COVID-19 indicated that doctors, nurses, and allied health workers experienced a higher rate of anxiety, burnout, compassion fatigue and decreased quality of life. The same results have been observed in Pakistan where healthcare professionals reported high patient mortality, shortage of human resources, violence at workplace and lack of psychosocial support to be of significant emotional burden. In the local setting of hospitals in Punjab, high level of death anxiety among healthcare professionals attending critically ill patients was established. Additionally, healthcare workers in KP also face regular high-stress and critical care scenarios that can have a negative impact on their psychological health and quality of life (Qayyum et al., 2023; Ullah et al., 2024; Rehana et al., 2023).

Patients with severe trauma, infectious diseases, cancer, life-threatening emergencies, and terminal illnesses are common patients of healthcare professionals. Death fatigue, fear of death, moral distress, and compassion fatigue are all associated with constant exposure to death. Death anxiety has a negative impact on concentration, clinical judgment, interpersonal communication, empathy, and job satisfaction. Before that, psychological distress is also associated with absenteeism, burnout, decreased productivity, and higher turnover rates for healthcare workers. These consequences directly affect the quality of care and patients' safety. Recent research has shown that the psychological stress of healthcare workers does not only occur in the workplace but rather has a negative impact on family relationships and well-being (Jain et al., 2024; Rashid et al., 2024).

Health-related quality of life is an important health outcomes variable for health care professionals, as it encompasses physical functioning, emotional health, social relationships, work or career satisfaction, and mental health. HRQoL has been correlated with higher medical errors, lower work engagement, chronic fatigue, depression, anxiety, and decreased patient satisfaction. Protecting the health of employees is becoming a top priority for healthcare organizations as a key element of sustainable healthcare delivery. A few recent studies have revealed a negative correlation between psychological distress and HRQoL in HCWs working in stressful clinical settings. Hospital administrators have turned to improving HRQoL as a priority since healthy professionals deliver safer, more effective patient care (Ullah et al., 2024; Rashid et al., 2024).

Self-efficacy is a psychological protective factor that has become an important factor in mitigating occupational stress. Healthcare professionals who have higher self-efficacy are more confident in their ability to handle emotionally charged situations, keep their competence, control their emotions, and adjust to workplace challenges. High self-efficacy fosters resilience, problem-solving, positive coping and psychological wellness. Reduced self-efficacy leads to low resistance to stress, anxiety, emotional exhaustion and low quality of life. Recent psychological

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studies have indicated that self-efficacy can buffer the effects of stressors on mental health. Considering self-efficacy as a moderator can help create programs that enhance resilience among healthcare workers (Bandura, 2021; Qayyum et al., 2023).

The country is still grappling with the issues of shortage of healthcare professionals, high volume of patients, lack psychological support services, and poor mental health resources in healthcare institutions. Tertiary hospital nurses, physicians and allied health professionals often have to deal with unexpected deaths and critically ill patients. Healthcare professionals have been found to experience psychological stress, burnout, work place violence, secondary trauma stress and loss of quality of life. Studies on death anxiety along with HRQoL and the moderating effect of self-efficacy in Pakistan remain limited especially in KPK. Context specific evidence is limited, which hinders psychological interventions, employee wellness programs and organizational policies for healthcare professionals (Rehana et al., 2023; Qayyum et al., 2023; Ullah et al., 2024).

This study is designed to investigate the effect of death anxiety on health-related quality of life among health care workers and to check whether self-efficacy is a moderator. This will help to gain insight into psychological factors playing a part in the health care system in Pakistan. The study will provide evidence for hospital administrators, nursing leaders, policy makers, and mental health workers to create interventions that build resilience, psychological counseling programs, and programs that boost self-efficacy. Better psychological health of healthcare professionals can lead to better workforce retention, patient safety, and provide better quality care and healthier health institutions (Jain et al., 2024; Khalid et al., 2023; Ullah et al., 2024).

Methods

This study will employ a quantitative, descriptive cross-sectional research design based on the positivist research paradigm. The positivist approach emphasizes objective observation, measurement, and statistical analysis to examine relationships among measurable variables. A descriptive cross-sectional design is appropriate because it enables the researcher to assess the levels of death anxiety, self-efficacy, and health-related quality of life among healthcare professionals at a single point in time. The study will be conducted in selected tertiary care hospitals. A convenience sampling technique will be used to recruit participants who meet the eligibility criteria. The study population will consist of registered healthcare professionals with at least one year of clinical experience in intensive care units, emergency departments, medical wards, and surgical wards. A total of **250 participants** will be included in the study. Data will be collected using a structured self-administered questionnaire comprising four sections: demographic characteristics, Death Anxiety Scale, General Self-Efficacy Scale, and a standardized Health-Related Quality of Life questionnaire. The selected design is appropriate for describing the prevalence of study variables and examining the moderating effect of self-efficacy on the relationship between death anxiety and health-related quality of life.

Data Collection Procedure

Prior to data collection, ethical approval will be obtained from the relevant Institutional Review Board (IRB) and administrative permission will be secured from the participating hospitals. Eligible healthcare professionals will be approached during their duty hours after obtaining permission from ward managers. The purpose, objectives, benefits, and voluntary nature of the study will be explained to all participants. Written informed consent will be obtained before questionnaire administration. Participants will be assured that their responses will remain confidential and anonymous, and that they may withdraw from the study at any stage without penalty. The questionnaires will be distributed personally by the researcher and collected immediately after completion or at a mutually convenient time. Data collection is expected to be completed over a period of approximately eight weeks.

Data Analysis Procedure

The collected data will be entered, cleaned, coded, and analyzed using the **Statistical Package for the**

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Social Sciences (SPSS) version 27.0. Descriptive statistics, including frequencies, percentages, means, and standard deviations, will be used to summarize participants' demographic characteristics and study variables. Pearson's correlation analysis will be performed to examine the relationships among death anxiety, self-efficacy, and health-related quality of life. Hierarchical multiple regression analysis will be conducted to determine the moderating effect of self-efficacy on the relationship between death anxiety and health-related quality of life by including an interaction term between death anxiety and self-efficacy. Statistical significance will be established at a **p-value of less than 0.05** with a **95% confidence interval**. The findings will be presented in tables and figures to facilitate interpretation and reporting

Results

Demographic Analysis

Table 1 Demographic Characteristics of the Participants (N = 250)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	9	3.6
	Female	241	96.4
Age (years)	Up to 20	50	20.0
	21–25	118	47.2
	26–30	63	25.2
	31–35	19	7.6
Qualification	Bachelor's	187	74.8
	Master's	63	25.2
Clinical Experience	Up to 1 year	43	17.2
	Up to 2 years	85	34.0
	Up to 3 years	51	20.4
	Up to 4 years	45	18.0
	Up to 5 years	26	10.4

Table 1 presents the demographic characteristics of the 250 healthcare professionals who participated in the study. The majority of participants were female (96.4%, *n* = 241), while only 3.6% (*n* = 9) were male, indicating that the study population was predominantly female. Regarding age, nearly half of the participants (47.2%, *n* = 118) were between 21 and 25 years, followed by 25.2% (*n* = 63) aged 26–30 years, 20.0% (*n* = 50) aged up to 20 years, and 7.6% (*n* = 19) aged 31–35 years. Most participants held a bachelor's degree (74.8%, *n* = 187), whereas 25.2% (*n* = 63) had a master's degree. In terms of clinical experience, the largest proportion (34.0%, *n* = 85) had up to two years of experience, followed by 20.4% (*n* = 51) with up to three years, 18.0% (*n* = 45) with up to four years, 17.2% (*n* = 43) with up to one year, and 10.4% (*n* = 26) with up to five years of experience.

Table 2 Descriptive Statistics of Study Variables (N = 250)

Variable	Number of Items	Mean ± SD (Item Range)	Skewness Range	Kurtosis Range
Death Anxiety (DA)	5	3.75 ± 0.92	-1.73 to -0.60	-1.67 to 7.14
Self-Efficacy (SE)*	6	3.80 ± 0.91	-0.50 to -0.28	-0.90 to -0.38
Health-Related Quality of Life (QOL)	4	3.96 ± 0.79	-0.47 to -0.16	-0.75 to -0.33

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Table 2 summarizes the descriptive statistics of the study variables, including death anxiety, self-efficacy, and health-related quality of life. The mean scores indicated that participants reported moderate to high levels across all three constructs. Death anxiety demonstrated an overall mean of approximately 3.75 with a standard deviation of 0.92, suggesting moderate levels of death-related concerns among healthcare professionals. Self-efficacy showed a mean score of approximately 3.80 with a standard deviation of 0.91, indicating that participants generally had a favorable level of confidence in managing work-related challenges. Health-related quality of life recorded the highest average mean (3.96 ± 0.79), reflecting a relatively good perception of physical, psychological, and social well-being. The skewness and kurtosis values for all variables were within acceptable ranges, indicating that the data were approximately normally distributed and suitable for subsequent parametric statistical analyses.

Table 3 Reliability and Validity of the Study Instruments (N = 250)

Variable	No. of Items	Cronbach's α	KMO	Bartlett's χ^2	df	p-value
Death Anxiety	5	.985	.834	699.083	10	<.001
Self-Efficacy	6	.979	.878	1823.210	15	<.001
Health-Related Quality of Life	4	.997	.808	492.155	6	<.001

Table 3 presents the reliability and validity results of the measurement instruments used in the study. The Cronbach's alpha values for death anxiety (.985), self-efficacy (.979), and health-related quality of life (.997) were substantially higher than the recommended threshold of .70, demonstrating excellent internal consistency of the scales. The Kaiser-Meyer-Olkin (KMO) values ranged from .808 to .878, indicating adequate to excellent sampling adequacy for factor analysis. Furthermore, Bartlett's Test of Sphericity was statistically significant for all three instruments ($p < .001$), confirming that the correlation matrices were appropriate for factor analysis and supporting the construct validity of the instruments. These findings indicate that the questionnaires used in the present study were both reliable and valid for measuring the intended constructs.

Table 4 Correlation, Regression, and Moderation Analysis (N = 250)

Analysis	Statistic	Result	p-value	Interpretation
Correlation	DA ↔ SE	r = .878	<.001	Strong positive correlation
	DA ↔ QOL	r = .674	<.001	Moderate positive correlation
	SE ↔ QOL	r = .785	<.001	Strong positive correlation
Regression	R^2	.454	<.001	DA explained 45.4% of the variance in QOL
	β (DA → QOL)	.674	<.001	Significant positive predictor
Moderation (PROCESS Model 1)	Overall Model R^2	.620	<.001	Model significant
	Interaction (DA × SE)	β = −.232	.221	Not significant
	R^2 Change	.002	.221	No moderating effect of self-efficacy

Table 4 presents the relationships among death anxiety, self-efficacy, and health-related quality of life, together with the regression and moderation analyses. Pearson's correlation analysis revealed

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statistically significant positive relationships between death anxiety and self-efficacy (r = .878, p < .001), death anxiety and health-related quality of life (r = .674, p < .001), and self-efficacy and health-related quality of life (r = .785, p < .001). Linear regression analysis showed that death anxiety significantly predicted health-related quality of life, explaining 45.4% of its variance (R^2 = .454, β = .674, p < .001). The moderation analysis further demonstrated that although the overall model was statistically significant (R^2 = .620, p < .001), the interaction term between death anxiety and self-efficacy was not statistically significant (β = −.232, p = .221). Therefore, self-efficacy did not significantly moderate the relationship between death anxiety and health-related quality of life among healthcare professionals, despite having a significant direct association with health-related quality of life.

Discussion

The present study examined the impact of death anxiety on health-related quality of life among healthcare professionals and explored the moderating effect of self-efficacy. The findings indicated that healthcare professionals experienced moderate levels of death anxiety, moderate to high self-efficacy, and relatively good health-related quality of life. The high proportion of female participants reflects the demographic profile of the nursing workforce in Pakistan and several other countries. The relatively young age and shorter clinical experience of most participants suggest that early-career healthcare professionals constitute a substantial proportion of the clinical workforce. Previous studies have also reported that younger healthcare professionals frequently encounter emotional distress while adapting to repeated exposure to patient suffering and death, which may influence their psychological well-being and professional functioning (Chen & Chen, 2024; Khalid et al., 2023).

The descriptive findings demonstrated moderate levels of death anxiety among healthcare professionals. Regular exposure to critically ill patients, unexpected deaths, emergency situations, and end-of-life care may contribute to these findings. Similar results were reported among Chinese nurses, where death anxiety remained a common psychological concern despite professional experience and clinical competence. Healthcare professionals working in intensive care and emergency settings often report emotional exhaustion and fear associated with frequent encounters with death. Research conducted among Pakistani healthcare professionals also identified moderate levels of death anxiety, particularly among professionals working in high-acuity clinical areas (Zhang et al., 2024; Khalil et al., 2023).

The participants demonstrated relatively high levels of self-efficacy and satisfactory health-related quality of life. High self-efficacy reflects confidence in managing occupational demands, coping with stressful situations, and maintaining professional performance. Similar findings have been reported among nurses in Europe and Asia, where stronger self-efficacy was associated with greater resilience, improved coping strategies, and better psychological adjustment after exposure to patient deaths. Higher self-efficacy enables healthcare professionals to regulate emotional responses and maintain confidence during difficult clinical situations. Studies have consistently shown that self-efficacy functions as an important psychological resource that supports professional well-being (Frontiers in Public Health, 2024).

The correlation analysis revealed statistically significant positive relationships among death anxiety, self-efficacy, and health-related quality of life. The positive association between death anxiety and health-related quality of life differs from the majority of published literature. Previous investigations have generally demonstrated that greater death anxiety is associated with poorer psychological well-being and lower quality of life. A recent systematic review and meta-analysis reported significant negative associations between death anxiety and quality of life across multiple populations. Healthcare professionals with higher death anxiety commonly report greater emotional distress, anxiety, depression, and occupational burnout. The discrepancy between the present findings and previous evidence may be related to differences in measurement tools, participant

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characteristics, workplace culture, or response patterns within the study population.

Regression analysis showed that death anxiety significantly predicted health-related quality of life and explained 45.4% of its variance. This finding confirms that psychological responses to death substantially influence healthcare professionals' overall well-being. Previous studies have similarly demonstrated that repeated exposure to patient deaths contributes to emotional exhaustion, compassion fatigue, burnout, and changes in professional quality of life. Research involving physicians and nurses found that subjective experiences related to patient deaths were more strongly associated with professional quality of life than the actual number of patient deaths experienced. Emotional interpretation of death experiences appears to influence psychological outcomes more than objective clinical exposure.

The moderation analysis demonstrated that self-efficacy did not significantly moderate the relationship between death anxiety and health-related quality of life. Self-efficacy exerted a significant direct effect on health-related quality of life but failed to weaken the influence of death anxiety. This finding contrasts with theoretical expectations and with studies suggesting that self-efficacy buffers the adverse effects of occupational stress on psychological outcomes. Differences in organizational support, workplace stressors, staffing shortages, workload, cultural factors, and access to psychological resources may explain the absence of a moderating effect. Recent evidence indicates that professional quality of life is influenced by multiple interacting psychological and organizational factors rather than by self-efficacy alone.

The findings emphasize the importance of strengthening psychological support systems for healthcare professionals working in high-stress clinical environments. Death anxiety remains an important occupational concern because persistent psychological distress may affect workforce retention, patient safety, professional performance, and healthcare quality. Hospital administrators should consider implementing resilience-building programs, psychological counseling services, stress management training, bereavement support, and continuing education focused on end-of-life care. Future studies should employ longitudinal and multicenter designs with larger samples to further examine the complex relationships among death anxiety, self-efficacy, and health-related quality of life across different healthcare settings. Recent systematic reviews also recommend organizational interventions that enhance coping strategies and emotional support for healthcare professionals exposed to frequent patient deaths.

Conclusion

The present study examined the impact of death anxiety on health-related quality of life among healthcare professionals and evaluated the moderating effect of self-efficacy. The findings demonstrated that healthcare professionals experienced moderate levels of death anxiety while reporting moderate to high levels of self-efficacy and health-related quality of life. Death anxiety was found to be a significant predictor of health-related quality of life, indicating that psychological responses to patient death and dying have an important influence on the overall well-being of healthcare professionals. Self-efficacy showed a significant direct association with health-related quality of life, suggesting that healthcare professionals with greater confidence in their abilities tend to report better well-being. The moderation analysis revealed that self-efficacy did not significantly moderate the relationship between death anxiety and health-related quality of life. Therefore, the hypothesis regarding the moderating effect of self-efficacy was not supported. The study highlights the importance of addressing death anxiety through organizational and psychological interventions to promote the health and well-being of healthcare professionals. The findings provide valuable evidence for hospital administrators, nursing leaders, and policymakers to develop strategies that enhance psychological resilience, improve workplace well-being, and maintain the quality of patient care.

Recommendations

Based on the findings of the study, the following recommendations are proposed:

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1. Hospital administrations should establish regular psychological counseling and mental health support services for healthcare professionals who are frequently exposed to patient death and end-of-life care.
2. Educational institutions and healthcare organizations should organize training programs on death education, grief management, stress management, and resilience-building to improve healthcare professionals' psychological preparedness.
3. Self-efficacy enhancement programs, including mentorship, simulation-based training, professional development workshops, and leadership support, should be implemented to strengthen healthcare professionals' confidence in managing emotionally demanding situations.
4. Nurse managers and hospital leaders should create supportive work environments by encouraging peer support, open communication, and debriefing sessions following critical incidents and patient deaths.
5. Policymakers should integrate mental health promotion and occupational well-being initiatives into national healthcare workforce policies to improve staff retention, job satisfaction, and quality of care.
6. Healthcare institutions should routinely assess death anxiety and health-related quality of life among healthcare professionals to identify individuals at risk and provide timely psychological interventions.
7. Future researchers should conduct multicenter studies with larger and more diverse samples to improve the generalizability of the findings across different healthcare settings.
8. Future studies should employ longitudinal or prospective research designs to examine changes in death anxiety, self-efficacy, and health-related quality of life over time.
9. Future research should investigate additional psychological and organizational factors, such as resilience, coping strategies, social support, burnout, compassion fatigue, emotional intelligence, and organizational climate, that may influence the relationship between death anxiety and health-related quality of life.
10. Intervention studies are recommended to evaluate the effectiveness of psychological counseling, mindfulness-based interventions, resilience training, and stress management programs in reducing death anxiety and improving the quality of life of healthcare professionals.

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