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# Navigating Ethical Dilemmas in End-of-Life Care: Lived Experiences of Filipino Nurses

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## Abstract

Introduction: End-of-life care requires nurses to navigate complex ethical, emotional, cultural, and advocacy-related demands. However, the lived experiences of Filipino nurses in providing end-of-life care remain insufficiently explored, particularly regarding ethical decision-making, emotional adaptation, and patient advocacy. Objective: This study described the lived experiences of Filipino nurses in providing end-of-life care, particularly in ethical decision-making, emotional adaptation, patient advocacy, and personal and professional transformation. Methods: A descriptive phenomenological design was employed. Data were collected through semi-structured, in-depth interviews conducted either face-to-face or virtually with seven Filipino nurses working in different hospitals in the United States, most of whom were based in Oregon. Participants were recruited through purposive and snowball sampling. Reflexive journaling was used to support reflexivity and reduce the influence of the researcher's preconceptions, and the data were analyzed using Colaizzi's phenomenological method. Results: Four themes emerged from the participants' experiences: (1) Prioritizing Comfort While Preserving Dignity at the End of Life; (2) Conflicting Views on End-of-Life Care; (3) Sentiments After Patients' Passing; and (4) Experiential Changes in Filipino Nurses' Personal and Professional Lives. Based on these findings, a preliminary debriefing guide was proposed by integrating key principles from the PEARLS and PAUSE frameworks. Conclusion: Filipino nurses remained committed to preserving patient dignity while navigating ethical dilemmas during end-of-life care. Their experiences reflected emotional adaptation, patient advocacy, and personal and professional transformation while supporting patients and families through the dying process.

Keywords:
End-of-Life Care, Ethical Dilemmas, Filipino Nurses, Lived Experiences, Phenomenology, Patient Advocacy



## INTRODUCTION

Providing end-of-life care to terminally ill patients may impose physical, emotional, and psychological burdens on healthcare providers while patients and their families also experience considerable emotional distress. Most patients diagnosed with advanced cancer or cancer-related

conditions eventually require palliative care. Pain is one of the major complications of cancer and significantly impairs patients' quality of life and activities of daily living, making effective pain management a central component of palliative care (Tagami et al., 2024). According to the National Cancer Institute (2021), although healthcare providers can estimate how long a patient with cancer may live, predicting life expectancy remains one of the most challenging aspects of cancer care because estimates may either overestimate or underestimate the actual prognosis. Global Cancer Statistics 2020 estimated the incidence and mortality of cancer across 185 countries and reported that cancer accounts for one in every six deaths worldwide (Sung et al., 2021). The increasing incidence and mortality of cancer highlight the growing need for nurses who are competent in providing comfort measures and supporting a dignified death.

As stated by Mughal and Evans (2020), death creates a need for families and healthcare providers to have adequate space and time to process this emotionally challenging experience. Likewise, a supportive physical environment enables nurses to address end-of-life care issues more effectively with bereaved families (Blazeviciene et al., 2017). End-of-life care is a demanding nursing specialty that requires ethical decision-making, respect for patients' and families' wishes, clear communication among all individuals involved, symptom management, cultural awareness, and the ability to cope with emotional demands. Respecting patients' wishes is a fundamental goal of end-of-life care, as patients and their families often seek to minimize suffering while preserving dignity during the final stage of life. According to the Philippine Board of Nursing Code of Ethics (Octaviano et al., 2004), Filipino registered nurses believe in the worth and dignity of every human being. Although preserving health remains a primary professional responsibility, nurses are also expected to assist patients toward a peaceful death when recovery is no longer possible. Similarly, Provision 1 of the Code of Ethics for Nurses states that nursing practice must respect the inherent dignity, worth, unique attributes, and human rights of every individual (American Nurses Association [ANA], 2025).

Although previous studies have explored end-of-life care, limited evidence is available regarding the lived experiences of Filipino oncology nurses practicing within multicultural healthcare settings in the United States. This study focuses on the lived experiences of Filipino nurses as they manage ethical dilemmas in end-of-life care within a multicultural healthcare system. Nurses are often expected to preserve life while simultaneously advocating for patients' wishes and preserving their dignity during the terminal phase of life. This study highlights how Filipino nurses fulfilled patients' wishes by providing care that was ethically appropriate, legally acceptable, and consistent with institutional policies and protocols as patients approached the end of life.

Repeated exposure to end-of-life care situations may also affect nurses' personal and professional well-being. Caring for patients with terminal cancer has been associated with psychosocial burnout caused by insufficient end-of-life care competency and the presence of ethical dilemmas (Seo & Yeom, 2022). Although nursing curricula provide substantial theoretical knowledge, students often have limited clinical exposure to end-of-life care and may feel unprepared when encountering patients' deaths. Accordingly, O'Shea and Mager (2019) suggested that additional education is needed. Similarly, Lai (2018) emphasized that further education and training on death and dying should be developed to enhance nurses' understanding of patients' individual needs and preferences. Jeong (2023) further recommended that healthcare institutions provide counseling and support programs to help oncology nurses reduce the psycho-emotional burden associated with end-of-life care.

This study aimed to describe, understand, and explore the lived experiences of Filipino oncology nurses in providing end-of-life care and how they negotiated ethical dilemmas, emotional responses, and professional responsibilities. Specifically, this study sought to answer the following questions: (1) What are the lived experiences of Filipino nurses in providing end-of-life care? and (2) What preliminary debriefing guide may be proposed based on Filipino nurses' end-of-life care experiences?

## METHODS

### 1. Design

This descriptive phenomenological study explored the lived experiences of Filipino nurses providing end-of-life care in medical oncology units. Phenomenology has long been recognized as an appropriate qualitative approach for understanding and describing individuals' lived experiences and the meanings they attribute to those experiences (Zahavi & Martiny, 2019). In this study, the phenomenological approach was used to explore nurses' experiences in caring for terminally ill patients, particularly how they encountered and managed ethical and moral dilemmas during end-of-life care. Because each nurse had unique experiences and perspectives, this design enabled participants to describe their experiences openly and reflect on how these encounters influenced their personal and professional lives. Descriptive phenomenology provides a rigorous approach for exploring and understanding human experiences from the participants' own perspectives (Neubauer et al., 2019).

### 2. Study Setting and Participants

Seven Filipino nurses working in medical oncology units in different hospitals across the United States were included in this study. Most participants were practicing in the State of Oregon and had direct

experience in providing end-of-life care to terminally ill patients. Participants were recruited using purposive sampling, followed by snowball sampling to identify additional eligible informants.

Data collection continued until no new patterns or meanings emerged from the interviews, indicating data saturation. Participant recruitment concluded after the seventh interview because the later interviews yielded highly consistent and repetitive information, with no substantially new patterns or meanings emerging. This sample size was considered appropriate, as phenomenological research emphasizes depth of understanding rather than numerical representation. Qualitative research seeks to achieve a comprehensive understanding of a phenomenon rather than statistical generalization (Polit & Beck, 2018).

The inclusion criteria were: (1) Filipino nurses who had immigrated to the United States; and (2) Filipino nurses working in medical oncology units in hospitals within the United States who had experience providing end-of-life care. Filipino nurses who were born and raised in the United States were excluded from the study.

No restriction was placed on years of nursing experience because the study aimed to capture diverse perspectives from nurses with varying professional backgrounds and levels of experience in providing end-of-life care. Participants ranged in age from 35 to 68 years and had between 2 and 45 years of nursing experience, allowing the study to capture a wide range of experiences and perspectives.

3. Data Collection Process

The primary research instrument was the researcher, who conducted all interviews and maintained a reflexive journal throughout the study to promote reflexivity during the research process. Three grand-tour questions guided the interviews: (1) What is it like to provide end-of-life care to patients? (2) What ethical dilemmas have you encountered during end-of-life care, and how did you manage them? and (3) What impact has providing end-of-life care had on your personal and professional life? Follow-up questions were used, when necessary, to encourage participants to elaborate on their experiences.

Data were collected from Filipino nurses working in hospitals across the United States, most of whom were based in the State of Oregon. Data collection and analysis were conducted over a nine-month period, from March to December 2025. Interviews were conducted either face-to-face or virtually, depending on the participants' availability and preference. Interview schedules were arranged at mutually convenient times for both the researcher and the participants.

With participants' permission, interviews were audio-recorded, and video recording was performed when consent was provided. Field notes and observations of participants' behaviors and non-verbal cues were documented throughout the interviews to complement the interview data. Google Meet was used for virtual interviews. To ensure privacy and confidentiality, participants were encouraged to attend the virtual interviews from their homes or other private locations. Although the researcher could not control the interview environment during virtual sessions, sufficient time was provided for participants to prepare an appropriate setting before the interview commenced.

The researcher maintained a reflexive journal throughout the study. Reflexive entries were recorded before data collection (March 2025), during data collection (April–May 2025), and during data analysis (August–December 2025) to enhance reflexivity throughout the research process.

4. Data Analysis

Data were analyzed using Colaizzi's (1978) descriptive phenomenological method. The analysis followed seven sequential steps. First, interview recordings and transcripts were reviewed repeatedly to achieve immersion in the data. Second, significant statements were identified through line-by-line coding and compared across participants' transcripts. Portions of the interviews conducted in Tagalog were translated into English as closely as possible to the participants' original wording and meaning. Bilingual verification was undertaken to confirm the accuracy of the translations.

Third, formulated meanings were developed from the significant statements. Fourth, similar meanings were clustered into categories, themes, and subthemes. Fifth, the themes were integrated into a comprehensive description of the phenomenon. Sixth, the comprehensive description was condensed into a concise statement representing the fundamental structure of the phenomenon. Finally, the fundamental structure and principal findings were returned to all participants for verification.

Participant recruitment and data analysis occurred concurrently. Data collection ceased after the seventh participant because no new information or meanings emerged and data saturation had been achieved.

5. Rigor and Trustworthiness

Trustworthiness was established through strategies addressing credibility, dependability, and confirmability. Credibility was enhanced through prolonged engagement with the data and member checking. The researcher returned the study findings, including the clustered themes, formulated meanings, thematic analysis, and interpretations, to all seven participants via email. All participants confirmed that the findings accurately reflected their experiences.

Dependability was maintained by applying a consistent interview process and data collection procedures across all participants. Transferability was supported by providing descriptions of the participants, professional context, study setting, sampling criteria, and relevant characteristics of the end-of-life care experiences examined. Confirmability was supported through the use of a reflexive journal, which enabled the researcher to continually reflect on

personal assumptions and minimize their influence on data interpretation throughout the study.

6. Research Ethics

Ethical approval for this study was obtained from the St. Paul University Manila Institutional Ethics Research Committee (Approval No. 2025-152-IMA-CNAHS). Ethical principles were strictly observed throughout the study to protect the rights, privacy, and well-being of all participants.

Prior to data collection, each participant was informed about the purpose of the study and was asked to provide voluntary informed consent before participation. Participants were informed that their participation was entirely voluntary and that they could withdraw from the study at any time without any consequences. All personal information was treated confidentially, and participants' privacy was respected throughout the research process.

To protect participants' identities, all identifying information was removed from the transcripts and each participant was assigned a unique code (NI1–NI7). The study focused exclusively on the nurses' lived experiences of providing end-of-life care and did not collect or report any patient-identifiable information.

## RESULTS

A total of seven participants are presented in Table 1. They were Filipino nurses working in medical oncology units in hospitals across the United States who had experience providing end-of-life care to terminally ill patients. The youngest informant was 35 years old with two years of nursing experience, whereas the oldest was 68 years old with 45 years of nursing experience. Most of the participants were working in Oregon at the time the interviews were conducted.

Thematic analysis generated four major themes and fourteen subthemes describing the lived experiences of Filipino nurses in providing end-of-life care. A summary of the emergent themes and subthemes is presented in Table 2.

**Table 1.** Participant Characteristics (*N* = 7)

| Nurse Informant Code | Age (Years) | Years of Nursing Practice | Current State |
|---|---|---|---|
| NI1 | 35 | 2 | Connecticut |
| NI2 | 39 | 14 | Indiana |
| NI3 | 41 | 4 | Oregon |
| NI4 | 54 | 30 | Oregon |
| NI5 | 38 | 5 | Oregon |
| NI6 | 36 | 15 | Oregon |
| NI7 | 68 | 45 | Oregon |

**Table 2.** Summary of Emergent Themes and Sub-themes

| Theme | Sub-themes |
|---|---|
| Theme 1: Prioritizing Comfort While Preserving Dignity at the End of Life | 1.1 Comfort as a Priority<br>1.2 Showing Compassion to Family Members<br>1.3 Providing Standardized Comfort Care Measures<br>1.4 Witnessing Patients' Deterioration |
| Theme 2: Conflicting Views on End-of-Life Care | 2.1 Differences in Cultural Preferences and Religious Beliefs<br>2.2 Misunderstandings Between the Healthcare Team and Patients' Families<br>2.3 Ethically Challenging Family Requests During the Active Dying Phase<br>2.4 Nurses as Patient Advocates<br>2.5 Reporting Challenges Encountered During Care |
| Theme 3: Sentiments After Patients' Passing | 3.1 Feelings of Gloom as Temporary Grief<br>3.2 Acceptance as Part of the Grieving Process<br>3.3 Reflecting on Oneself and Family |
| Theme 4: Experiential Changes in Filipino Nurses' Personal and Professional Lives | 4.1 Modifying Care for Dying Patients and Their Families<br>4.2 Personal Transformation and Professional Growth |

1. Theme 1: Prioritizing Comfort While Preserving Dignity at the End of Life

1.1 Sub-theme 1: Comfort as a Priority

Nursing care does not stop when patients and their families decide to transition to comfort care; rather, it does not mean that nurses stop caring, showing compassion, or demonstrating understanding. Although resuscitative efforts may be

discontinued, the provision of comfort measures and dignified end-of-life care continues. Participants viewed comfort as an essential ethical responsibility in caring for dying patients and supporting grieving families while alleviating symptoms and suffering. NI1 shared:

*"It encompasses our vision of care in end-of-life, like promoting comfort with the patients, like alleviating their pain."*

Similarly, NI2 added:

*"It deals with patients nearing death… how to make it more comfortable for them."*

Another participant shared:

*"They should be given all the comfort until the end of their life; in our institution, we call it 'comfort care,' so it's basically their comfort." (NI3)*

Three participants expressed similar views:

*"Make them comfortable." (NI5, NI6, NI7)*

These responses demonstrate that participants viewed comfort and dignity as fundamental components of ethical end-of-life nursing care.

NI4 further emphasized that, beyond providing comfort, nursing care also involves preserving patients' dignity until their final moments:

*"Keeping the patient comfortable… for me, that should be like two different parts. First, of course, for the patient, you have to take care of their dignity first of all."*

### 1.2 Sub-theme 2: Showing Compassion to Family Members

All participants described how they cared not only for patients but also for their grieving family members. NI1 shared:

*"We are preparing the families… to accept that the patient will soon be gone."*

Behind anticipatory grief are untold stories that often make it difficult for families to accept the impending loss of their loved ones. Although education is important throughout this process, nurses also emphasized the importance of awareness, compassion, and sensitivity. Being mindful and compassionate while families experience emotional crises was considered essential, particularly during the initial stage of grief, when denial is commonly experienced. Participants regarded these situations as one of the most challenging aspects of caring for patients receiving comfort care.

NI1 further explained:

*"The hardest part…. dealing with their families, who are in the emotional state of accepting that someone from their family is already dying."*

Similarly, NI4 stated:

*"It's hard, especially if you have aggressive family members or if they are not ready."*

However, NI3 described the frustration that may arise when family members disregard hospital policies:

*"They want their own decisions to be followed even if it's against the hospital rules... It's really just frustrating."*

In contrast, NI7 shared that understanding families often begins with personal reflection:

*"As usual, you'll reflect on your own family."*

Participants also acknowledged that certain situations require flexibility, even when family requests occasionally conflict with hospital policies. Four participants described circumstances in which they allowed additional visitors or extended visiting hours to accommodate the emotional needs of patients and their families. NI2 explained:

*"We allow as much relatives, they can stay overnight, they can come anytime."*

Similarly, NI4 stated:

*"When you are in that situation, you cannot implement what you believe or what is your policy; you have to adjust to the patient or to the patient's family."*

While families remained in the hospital, participants also described providing support beyond direct patient care. NI5 shared:

*"If they need something to make them feel a little less or to help with what they're going through."*

Likewise, NI6 stated:

*"We follow what the family is requesting, as long as the family is comfortable but still within the acceptable protocol and set of rules."*

### 1.3 Sub-theme 3: Providing Standardized Comfort Care Measures

Filipino nurses emphasized the importance of first understanding the determinants of comfort before providing end-of-life care. Various assessment parameters and pain assessment tools were used to determine whether patients were experiencing pain through either subjective or objective indicators. Participants described that every nursing intervention was preceded by a comprehensive assessment.

Three pain assessment approaches were identified. First, participants referred to the EPIC flowsheet, an electronic health record documentation system commonly used in healthcare institutions in the United States. NI1 explained:

*"Follow the flowsheet in Epic."*

Second, participants described using the Numeric Pain Rating Scale when patients were able to communicate their pain. However, when patients were unconscious or unable to respond, objective assessment methods were used. As NI2 stated:

*"Pain scale… but if the patient is unconscious… more on like objective symptoms."*

Participants also reported using the Pain Assessment in Advanced Dementia (PAINAD**)** scale and the Respiratory Distress Observation Scale (RDOS), in addition to observing patients' non-verbal behaviors. NI6 shared:

*"The one we have, PAINAD and RDOS."*

Other participants relied on behavioral indicators of discomfort to determine whether patients were experiencing distress. NI4 explained:

*"They are struggling breathing, that's not comfortable, right?"*

Similarly, NI7 stated:

*"Trying to get out of the bed, he pulled his IV, he pulled out his condom cath… you really feel that they are in a lot of pain."*

Participants explained that supportive treatments were provided to relieve distress and promote comfort, with symptom management serving as one of the primary goals of end-of-life care. They also acknowledged that assessment practices may vary across healthcare institutions and should be performed according to institutional policies. As NI3 explained:

*"Depends on the institution's policy."*

Likewise, NI5 stated:

*"I honestly just go by what policy says."*

Participants further emphasized that caring for patients receiving comfort care requires both pharmacological and non-pharmacological interventions. They continued to provide routine nursing care, including repositioning, emotional and physical support, oral care when patients were no longer able to perform self-care, wound care, and ongoing assessments, provided that these interventions did not increase patients' discomfort.

### 1.4 Sub-theme 4: Witnessing Patients' Deterioration

Participants described witnessing the gradual deterioration of patients throughout the course of their illness. Because patients with cancer are frequently admitted for treatment and follow-up consultations, nurses often develop ongoing relationships with them and observe the progression of their condition over time.

NI1 recalled conversations between patients and their families regarding prognosis:

*"They discussed the patient's status that even continuing with care, there will be less chances of survival."*

The same participant further explained:

*"You will see some of them slowly degrade… from full code transitioned to DNR/DNI to comfort care."*

Similarly, NI2 observed:

*"Transferred to ICU and come back again in our unit for comfort measures."*

Participants emphasized that, although patients may remain capable of making their own healthcare decisions, identifying the patient's significant family members remains essential. This allows healthcare providers to prepare families for the patient's impending death while respecting their beliefs, values, and preferences. NI7 stated:

*"It's the choice of the patient and family."*

Likewise, NI3 emphasized the importance of interdisciplinary communication and shared decision-making:

*"We should bring it up to the care team, to the doctor, or whoever, so they can discuss further with the patient and their family, make sure that everyone is agreeing on the right decision."*

## 2. Theme 2: Conflicting Views on End-of-Life Care

### 2.1 Sub-theme 1: Differences in Cultural Preferences and Religious Beliefs

Filipino nurses working in the United States provide care to patients from diverse cultural and ethnic backgrounds. Participants described how cultural preferences and religious beliefs influenced patients' and families' responses to end-of-life care. NI1 shared that he had cared for American, Hispanic, and Filipino patients and observed noticeable differences in how families responded during the dying process:

*"It depends on their ethnicity, especially if they are with their families; his favorite daughter was at bedside, and his wife, and they just being there was already the comfort of the patient."*

NI1 further explained that Hispanic, Latino, and Filipino families often remained at the patient's bedside throughout hospitalization. Regardless of these cultural differences, participants emphasized that they provided the same standard of care to every patient.

Similarly, NI4 observed similarities between Mexican and Filipino families:

*"They have big families; when somebody is sick, everybody has to be there."*

In contrast, participants perceived that American families were generally more familiar with and accepting of end-of-life care. NI2 stated:

*"They [Americans] are very open with it. Most of the time, if they see that their relative is already in a difficult situation, they would just let go."*

NI4 shared a similar observation:

*"Because palliative care here in America is very acceptable."*

Another participant described a culturally specific practice observed during end-of-life care but was unable to identify the patient's ethnicity. NI6 explained:

*"You need to cover them first, then special clothes need to be put on instead of wearing a gown. Some need to stay in bed for a few hours, and they will hold a ceremony."*

Participants also acknowledged that providing culturally appropriate end-of-life care often required flexibility and respect for patients' cultural and religious beliefs. NI4 expressed the challenges of caring for patients from diverse backgrounds:

*"We have to adjust to everything. We have to adjust to the family's culture and their beliefs and their religion, even though you don't believe in it, right?"*

Participants recognized that respecting patients' cultural practices and religious beliefs demonstrates compassion and respect despite cultural diversity. However, they also emphasized that differences in religious affiliation were not considered barriers to providing compassionate end-of-life care.

### 2.2 Sub-theme 2: Misunderstandings Between the Healthcare Team and Patients' Families

Participants described situations in which differences in understanding between healthcare

providers and patients' families created ethical and moral challenges during end-of-life care. NI2 explained that family members often had varying levels of understanding regarding the patient's condition and the goals of comfort care:

*"Not everyone has the same level of understanding, given the stressful situation."*

One common misunderstanding involved nutrition during the terminal phase. Family members sometimes perceived that withholding oral intake meant starving their loved one, whereas nurses recognized that continued feeding could place the patient at risk for aspiration. Participants emphasized that these situations often complicated clinical decision-making.

Another concern involved the administration of pain medications during the terminal phase. Participants described situations in which frequent administration of analgesics raised ethical concerns. NI3 shared:

*"They wanted to medicate the patient, even if the patient does not need it."*

### 2.3 Sub-theme 3: Ethically Challenging Family Requests During the Active Dying Phase

Participants described encountering family requests that were ethically challenging while patients were actively dying. Some requests were perceived as inconsistent with the patient's best interests or with the goals of end-of-life care. These situations commonly involved requests related to artificial nutrition despite the risk of aspiration, continued aggressive treatment, frequent administration of pain medications, and conflicts concerning financial or insurance matters following the patient's death. As NI2 explained:

*"Not everyone has the same level of understanding…"*

Participants noted that some family members questioned why patients were no longer receiving food despite the risk of aspiration. Similarly, NI6 shared:

*"Family wants to feed them, and work with a physical therapist making them stronger."*

Participants also described situations in which family members appeared to prioritize personal interests over the patient's comfort. NI6 recalled:

*"There's this one family member that would like to make the dying process of the patient faster because that person was after the patient's insurance."*

Likewise, NI7 stated:

*"They're talking about the will, they're talking about whatever is left behind… by their father."*

Other participants encountered requests for unnecessary medication during the dying process. NI3 explained:

*"They wanted to medicate the patient even if the patient does not need it… I don't want to think about it but it's almost like bordering on saying that they want to end the patient's life faster."*

### 2.4 Sub-theme 4: Nurses as Patient Advocates

Participants consistently described patient advocacy as one of their primary professional responsibilities during end-of-life care. They emphasized that advocating for patients means protecting patients' rights, respecting their wishes, and supporting decisions that are in the patient's best interests. NI3 stated:

*"We should be the number one patient's advocate, right?"*

Similarly, NI4 shared:

*"I listen to the patient, I am a patient advocate rather than the family."*

NI6 also emphasized:

*"As long as they can still make decisions for themselves, the patient would still be the decision maker."*

Participants recognized that the terminal phase is often emotionally difficult for family members. Nevertheless, they emphasized the importance of respecting patients' autonomy whenever patients remained capable of making their own decisions. NI2 shared that she consistently encouraged advance discussions regarding patients' wishes:

*"I advised my patients… that if you are unable to make decisions of your own or you are already… you know… unconscious, try to let them know what you really wanted."*

These responses illustrate that participants viewed patient advocacy as protecting patients' autonomy and ensuring that care remained aligned with their preferences and best interests.

### 2.5 Sub-theme 5: Reporting Challenges Encountered During Care

Participants explained that when conflicts or difficulties arose while providing end-of-life care, they sought guidance and support from their immediate supervisors, particularly the charge nurse. NI3 stated:

*"I will relay it to my charge nurse and raise my concerns about it."*

Similarly, NI5 shared:

*"I will talk to my charge nurse and consult with them."*

NI6 likewise explained:

*"I reported it to my Charge Nurse."*

Participants emphasized that consulting the charge nurse helped them address challenging situations while ensuring that patients' rights and best interests remained the primary focus of care. Despite these support mechanisms, participants acknowledged that interactions with patients' family members could still be emotionally and ethically challenging.

## 3. Theme 3: Sentiments After Patients' Passing

### 3.1 Sub-theme 1: Feelings of Gloom as Temporary Grief

Caring for terminally ill patients and witnessing their deaths can be a highly emotional experience for nurses. Although death is often regarded as an expected part of nursing practice, participants

emphasized that nurses are also human beings who experience emotional responses when caring for dying patients. Most participants described feeling sadness following the death of their patients. NI1 shared:

*"You cannot avoid the feeling of sadness, too."*

Similarly, NI2 described the emotional burden associated with patients' deaths:

*"It makes me sad too… You need to dissociate yourself from your work because it is difficult to carry that burden; it's so stressful."*

NI7 also expressed strong emotional involvement with patients:

*"I'm a strong person but when it comes to a patient dying, you will see that I'm the first one to cry. I'm very emotionally involved when it comes to patients."*

Likewise, NI6 recalled the emotional impact of experiencing a patient's death for the first time:

*"At first, it really made me sad; it was depressing."*

NI4 acknowledged that these experiences were never easy and reflected on the emotional challenges associated with end-of-life care:

*"It's not always easy; I was so distraught… it was a good thing that I have a very supportive nursing staff. But of course, you would think, did I trigger or did I help him die?"*

### 3.2 Sub-theme 2: Acceptance as Part of the Grieving Process

Participants described acceptance as an important part of the grieving process experienced by both families and nurses. They recognized that patients receiving end-of-life care had reached a stage where the primary goal of care was to provide comfort rather than curative treatment. Consequently, participants described accepting the situation while continuing to provide compassionate care. NI1 stated:

*"The reason why that patient is a comfort patient is because they are terminally ill and actively dying."*

Similarly, NI2 shared:

*"They are on the stage of acceptance… they are fine with it."*

NI7 also emphasized the importance of acknowledging how families cope with the situation:

*"You also have to regard your family, how to accept that, how they accept it."*

### 3.3 Sub-theme 3: Reflecting on Oneself and Family

Participants described how caring for dying patients encouraged them to reflect on the importance of family and their own mortality. Witnessing patients approach the end of life prompted many participants to appreciate the presence of loved ones and to empathize more deeply with patients and their families.

NI3 emphasized the importance of family support during end-of-life care:

*"There's a very stark difference between comfort care patients who deal with it alone compared to a comfort care patient who deals with a loving family around them. So, maybe appreciate your loved ones."*

Similarly, NI4 highlighted the importance of empathy in nursing practice:

*"Empathy, that's also important, right, because sometimes we just forget to put ourselves in their shoes."*

Participants also reflected on their own lives and family relationships while caring for dying patients. NI1 shared:

*"Even when I'm still in the Philippines, I take care of my patients the way my parents wanted to be taking care of… you'll think of what if this happens to my family."*

Likewise, NI7 expressed how caring for a patient reminded her of her father:

*"When I looked at the patient that I had yesterday, when I look at him, I can see my father in him."*

NI2 also described how these experiences increased her awareness of advance care planning:

*"You open yourself in certain situation like thinking what you want when you are gone, should I write my advance directives ahead of time."*

## 4. Theme 4: Experiential Changes in Filipino Nurses' Personal and Professional Lives

### 4.1 Sub-theme 1: Modifying Care for Dying Patients and Their Families

Participants described how repeated exposure to terminally ill patients and end-of-life care influenced the way they provided nursing care. Through their experiences, they adapted their approach according to patients' needs while maintaining compassionate and dignified care.

NI1 explained that one of the major changes involved increasing the frequency of patient monitoring:

*"If you have regular patients, the rounding is like every 2 hours, especially on night shift, but for comfort patients, I do it every 30 minutes, just to assess if they are in pain."*

Other participants described becoming more understanding, compassionate, and patient when caring for dying patients and their families. NI2 shared:

*"I became more understanding to the patient and family… more compassionate, and more patient."*

Similarly, NI3 stated:

*"Everyone stressed out about what's happening with their situation; it forced me to become more understanding… to become more patient."*

NI4 also emphasized the development of greater empathy and awareness while providing end-of-life care:

*"I feel more caring to other patients and the empathy is more triggered… I think I'm more conscious of how to take care of my patients, keeping them dignified."*

Although participants described adapting their approach to care, they also emphasized the importance of practicing within professional and institutional standards. NI7 explained:

*"Anything you do, you have to do it according to their, you know, their laws and rules."*

4.2 Sub-theme 2: Personal Transformation and Professional Growth

Participants described how caring for dying patients influenced both their personal lives and professional development. Repeated exposure to end-of-life care encouraged self-reflection, increased awareness of mortality, and strengthened their commitment to providing compassionate care.

Some participants viewed these experiences as reminders to value their own health and the well-being of their loved ones. NI1 stated:

*"I want to prevent this from happening to me, to my family, personally."*

Similarly, NI7 reflected:

*"I just think of myself… like I could get to this point."*

NI2 also shared that these experiences encouraged conversations about future healthcare preferences:

*"To everyone I know who's getting older, I give them advice. I advised them to think of their wants."*

Participants also described different coping strategies for managing the emotional impact of end-of-life care. NI4 explained that discussing difficult experiences with her husband helped her process her emotions after work:

*"I just tell my husband stories, that's it. I mean, I guess, just my outlet, but after that, I mean, I'm good. I'm not really trying to get it on me at home; I don't bring it at home."*

In contrast, NI3 described becoming emotionally stronger while recognizing the need to temporarily regulate emotions during work:

*"Maybe stronger I think emotionally because whenever you go to work, you have to shut down at least a part of your emotional nature to deal with it, just to go through the day to take care of them, and then just be emotional back home."*

Other participants expressed professional satisfaction from knowing they had provided the best possible care. NI5 stated:

*"I just went on with my day… as long as I know that I provided the utmost care for my patient."*

Similarly, NI6 shared:

*"Just go through my shift."*

5. Proposed Debriefing Guide

Based on the study findings, the researcher proposed a preliminary debriefing guide for nurses named LIVE IT. The acronym LIVE IT represents six sequential components: Lay the Groundwork; Invite and Introduce; Validate and Review the Experience; Express Concerns and Feelings; Investigate Coping, Identify Insights, and Improve Practice; and Time-Bound Takeaways and Thanks. The name also reflects the guide's emphasis on helping nurses acknowledge, verbalize, and process their lived emotional experiences following patients' deaths rather than carrying these experiences without structured support. The guide is a preliminary conceptual output developed from the findings of this study and adapted from the PEARLS and PAUSE debriefing frameworks. It is presented in Table 3.

The proposed guide consists of six components: (1) preparing the setting; (2) inviting the individuals involved and providing an introduction; (3) validating experiences and reviewing the case; (4) encouraging participants to verbalize concerns and express their feelings; (5) exploring coping mechanisms, insights, and areas for improvement; and (6) concluding the session by establishing time limits, identifying key takeaways, and acknowledging participants' involvement.

The primary purpose of the proposed guide is to facilitate reflection following patients' deaths, encourage nurses to acknowledge and process their emotional responses, strengthen coping strategies, promote peer support within the healthcare team, and identify opportunities to improve end-of-life nursing practice. The guide also aims to encourage self-care and reflective practice following emotionally challenging clinical experiences.

## DISCUSSION

The first theme emphasizes how Filipino nurses prioritized patients' comfort above all else. Despite the decision to discontinue resuscitative efforts, nursing care did not cease. Rather, the focus shifted from prolonging life to providing comfort and ensuring a peaceful and dignified death. This unique aspect of nursing practice demonstrates that caring continues even when curative treatment is no longer possible. Providing a dignified death is emphasized in both the Philippine Code of Ethics for Registered Nurses (Octaviano et al., 2004) and the American Nurses Association's Code of Ethics for Nurses (ANA, 2025), both of which recognize nurses' responsibility to preserve patients' dignity and support them throughout the dying process.

During this stage, two groups are primarily involved: (1) the dying patient and (2) the patient's family. Although the patient remains the primary focus of care, participants emphasized that nurses also attended to the needs of family members, particularly as they witnessed the progressive decline of their loved ones. Supportive care is essential during the terminal phase to prevent and alleviate the cascade of symptoms and suffering (ANA, 2025). Likewise, prioritizing comfort through effective symptom control remains a fundamental goal of end-of-life care (National Coalition for Hospice and Palliative Care, 2025).

**Table 3.** LIVE IT: A Preliminary Debriefing Guide for Nurses Following End-of-Life Care Experiences

| **LIVE IT** | |
|---|---|
| NAME: | DATE/TIME: |
| POSITION: | UNIT/DEPARTMENT: |
| **Case Review** | |
| Can you provide a brief summary on what happened on this case? | |
| **Concerns and Feelings** | |
| What is your initial reaction? | |
| How are you feeling? | |
| What have you done to help this patient? | |
| What makes it emotionally challenging? | |
| Any concerns that you want to talk about? | |
| **Investigate, Insights, Improve** | |
| How do you cope when you are in difficult situation? | |
| What's your recommendation / suggestion if same event will happen again? | |
| **Takeaways** | |
| Any lesson learn while taking care of this patient and dealing with the death and dying? | |
| **Facilitator:** | |

Education was also considered an important component of end-of-life care. Participants explained that they often used layman's terms or educational booklets to help patients and their families better understand palliative care. Consistent with previous recommendations, discussions about palliative care should begin early rather than only when patients are approaching the end of life (De Swardt et al., 2024). Despite these efforts, denial among family members remained common, particularly when patients deteriorated unexpectedly. Participants described how this sometimes resulted in frustration when family members questioned or disregarded hospital policies. Similarly, De Brasi et al. (2021) reported that moral distress often arises from miscommunication among healthcare providers, patients, and families, as well as from situations in which patients' wishes are not respected. Therefore, identifying the patient's key decision-makers remains an important component of end-of-life care (Crawford et al., 2021).

Participants also described different approaches to assessing patients' comfort, including the numeric pain rating scale, electronic flowsheets, and observations of non-verbal cues. These assessment methods guided nurses' clinical decision-making regarding symptom management and the need for pharmacological interventions. These findings are consistent with current palliative care literature, which emphasizes that both subjective and objective assessment methods are essential for evaluating symptom burden and guiding appropriate pharmacological interventions (Kero et al., 2024). Validated assessment tools also support timely opioid titration for respiratory distress (Hare, 2025), whereas opioids remain the medication of choice for managing respiratory distress and palliative sedation may be considered for patients with refractory symptoms or severe agitation (Albert, 2017; Klein et al., 2023). Collectively, these approaches supported Filipino nurses in determining when clinical interventions and symptom management were necessary.

The second theme highlights the conflicting views surrounding end-of-life care. Participants revealed that patients and their families held different perspectives influenced by cultural preferences, spiritual beliefs, and religious practices, requiring nurses to adjust their approach to care. Participants perceived similarities between Mexican and Filipino families in the strong involvement of relatives when caring for seriously ill family members, whereas they viewed American families as generally more accepting of end-of-life care decisions. These perceptions are consistent with previous studies showing that cultural values influence family involvement, communication, and decision-making in end-of-life care across different cultural contexts (Fink et al., 2023; McParland et al., 2025; Pun et al., 2023).

Despite these differences, participants reported maintaining comparable professional standards while adapting care to patients' cultural and spiritual needs. Regardless of patients' beliefs, nurses adjusted their care according to patients' cultural and spiritual needs while continuing to fulfill their professional responsibilities and provide the best possible care (Alshammari et al., 2023). However, this finding differs from that of Alanazi et al. (2024), who reported that moral distress may arise when nurses are unable to practice in accordance with their own beliefs.

This theme also highlights how some patients and family members held misconceptions about end-of-life care. Nutrition remained one of the most controversial issues, as withholding oral intake was sometimes misunderstood as neglect, euthanasia, assisted suicide, torture, or intentionally allowing the patient to die slowly and painfully (Pinho-Reis et al., 2018). Participants explained that some family

members perceived the decision to keep patients nothing per orem (NPO) as starving their loved ones, whereas nurses considered it necessary to reduce the risk of aspiration and maintain patient comfort.

Participants also described ethically challenging situations encountered during end-of-life care, including inappropriate family requests, reportable concerns during care, and their role as patient advocates. They explained that family members occasionally requested additional pain medications or interventions intended to hasten the dying process. Participants consistently emphasized their responsibility to advocate for patients by ensuring that care remained consistent with patients' best interests and professional standards. They also encountered situations involving disagreements over patients' possessions and inheritance after death. These findings are consistent with previous studies demonstrating that family conflict and ethically challenging requests are common in end-of-life care, requiring nurses to balance patient autonomy, family expectations, and professional responsibilities through effective communication and patient advocacy (Kwon et al., 2022; Semler et al., 2025; Wilson et al., 2025).

The third theme highlights the sentiments experienced by Filipino nurses following their patients' deaths. Participants described various emotional responses after losing a patient, including feelings of gloom, acceptance, and reflection on themselves and their family members. Although losing a patient is different from losing someone close to them, participants had cared for these patients throughout their illness, witnessed their gradual deterioration, and remained with them during their final moments. These firsthand experiences made patient death emotionally challenging despite being an expected part of oncology nursing practice.

Caring for terminally ill patients and witnessing their deaths can be a highly emotional experience for nurses. Although death is often regarded as a normal part of the nursing profession, participants emphasized that nurses are also human beings who experience grief and emotional reactions in such situations. Maintaining professionalism requires nurses to remain composed during emotionally challenging events while continuing to support patients' families throughout the grieving process. Consistent with these findings, witnessing a patient's death has been associated with high levels of stress, emotional exhaustion, and burnout among nurses (Kostka et al., 2021). Participants also described their first experience with a patient's death as the most emotionally difficult. Similarly, Makowicz et al. (2019) emphasized that providing a dignified death is one of the most ethical responsibilities of nursing care, while Cybulska et al. (2022) reported that many nurses continue to remember their first encounter with death and dying because of its profound emotional impact.

Participants further described reaching a stage of acceptance as they recognized that patients receiving comfort care had entered the terminal phase of illness. Acceptance enabled them to continue providing compassionate care while respecting patients' dignity and supporting families during the dying process. In addition, caring for dying patients encouraged participants to reflect on themselves and their family members. Many expressed a greater appreciation for spending time with loved ones and reflected on how they would want themselves or their own family members to be cared for in similar situations. These experiences demonstrate that caring for dying patients influenced not only participants' professional practice but also their personal perspectives on life, death, and family.

The fourth and final theme highlights the experiential changes in Filipino nurses' personal and professional lives after caring for terminally ill patients. Participants described modifications in the way they cared for dying patients and their families, as well as personal transformation resulting from their experiences. As they expressed, being a nurse means either touching the lives of others or being touched by the lives of their patients. Every patient encounter left a lasting impression, influencing both their personal and professional lives.

Participants explained that repeated exposure to end-of-life care changed the way they approached nursing practice. Some described going beyond routine nursing responsibilities by providing additional care and support to dying patients and their families. Others reported becoming more compassionate, caring, patient, and understanding toward grieving family members. These findings reflect how their experiences influenced not only the delivery of care but also their attitudes toward patients and families during the terminal phase.

Nurses perform multiple responsibilities in their daily practice, including admitting and discharging patients, conducting assessments, administering medications, reassessing patients, and evaluating their responses to treatment. Within the oncology setting, patient death is an inevitable part of clinical practice. Participants acknowledged that losing a patient never becomes easy, even after years of experience. One moment patients are alive, and the next, nurses are faced with informing families of their death. Although these situations remain emotionally difficult, participants explained that they gradually developed better coping strategies and self-care practices by seeking help and utilizing available support resources, which is consistent with the findings of Rodgers (2019).

Participants also emphasized the importance of maintaining professionalism despite experiencing personal grief. They often had little opportunity to pause, process their emotions, or grieve before continuing to care for other patients. As a result, nurses' emotional responses were frequently overlooked. Similar experiences may reactivate previous emotional distress or increase empathy toward future patients (Du et al., 2024). Furthermore, oncology nursing has been associated with psychosocial consequences, compassion fatigue, burnout, and reduced compassion satisfaction (Jarrad & Hammad, 2020). The high mortality associated with

cancer also contributes to the emotional demands experienced by oncology nurses (Uzunkaya Oztoprak & Terzioglu, 2024).

Participants identified support from colleagues and loved ones as an important coping resource. Peer support from co-workers was viewed as a form of shared grief, while support from family members provided an opportunity to express emotions after emotionally challenging shifts. Professional guidance has identified peer support, opportunities for emotional expression, and workplace wellness activities as potential coping resources for oncology nurses (Winzeler, 2020). For several participants, their loved ones became an important source of emotional support after caring for dying patients.

A proposed debriefing guide derived from the study findings still requires future validation before clinical implementation. The proposed LIVE IT guide was developed by integrating key principles from the PEARLS Healthcare Debriefing Tool (Bajaj et al., 2018) and the PAUSE framework (Ulin et al., 2023), while adapting its content to reflect the lived experiences of Filipino oncology nurses caring for patients at the end of life. Its primary purpose is to facilitate structured reflection following challenging clinical encounters, support nurses in acknowledging their emotional responses, strengthen coping strategies, promote psychological safety, and improve future nursing practice.

### Implications for Practice and Future Research

This study has several implications for nursing practice. First, nurses assigned to units providing end-of-life care should receive structured pre-exposure education and training to strengthen their competence in ethical decision-making, communication, symptom management, and culturally sensitive care. Second, healthcare institutions should establish or strengthen structured debriefing programs to support nurses following emotionally challenging events. Third, nurses should be encouraged to practice self-care, and healthcare organizations should provide supportive environments where nurses and other healthcare professionals can briefly rest, reflect, and process grief after patients' deaths.

Hospitals may consider integrating structured debriefing and psychological support into end-of-life care services to support nurses' well-being and potentially strengthen the quality of care.

Future research should include larger and more diverse samples of Filipino nurses from different healthcare settings. Studies involving patients, family members, and other healthcare professionals are also recommended to provide a broader understanding of end-of-life care experiences. In addition, future studies should evaluate the feasibility and effectiveness of the proposed LIVE IT Debriefing Guide before its implementation in clinical practice.

### Limitations

The strength of this study lies in its use of Colaizzi's descriptive phenomenological method to explore the lived experiences of Filipino nurses providing end-of-life care in the United States. It also addresses an important yet relatively underexplored aspect of nursing practice from the perspective of Filipino immigrant nurses.

However, several limitations should be acknowledged. First, this study employed a descriptive phenomenological design; therefore, the findings reflect participants' lived experiences and are not intended to be generalized beyond the study context. Second, only seven participants were included using purposive and snowball sampling, which may have introduced sampling bias and limited the diversity of experiences represented. Third, some interviews were conducted virtually, limiting the researcher's control over the interview environment. Finally, the study focused solely on Filipino nurses' perspectives and did not include the experiences of patients, family members, or other healthcare professionals.

## CONCLUSION

This study explored the lived experiences of Filipino nurses providing end-of-life care in hospitals across the United States. The findings revealed that, despite the ethical, emotional, and cultural challenges encountered in end-of-life care, Filipino nurses consistently prioritized patients' comfort, preserved their dignity, and advocated for patients' best interests while supporting their families throughout the dying process. Participants also described conflicting cultural and family perspectives, emotional responses following patients' deaths, and personal and professional changes resulting from repeated exposure to terminal care.

Beyond describing these lived experiences, this study contributes to the existing body of knowledge by providing an in-depth understanding of how Filipino nurses navigate ethical dilemmas, cultural diversity, emotional adaptation, and patient advocacy in end-of-life care within a multicultural healthcare setting. The findings also provide a preliminary conceptual foundation for the proposed LIVE IT Debriefing Guide, which may support future research and the development of structured debriefing programs for nurses caring for terminally ill patients. However, the proposed guide requires further validation before clinical implementation.

Overall, this study highlights the importance of preparing nurses not only with clinical competence but also with emotional support and coping strategies to sustain compassionate, patient-centered, and dignified end-of-life care.

de Dios.

## Author Contributions

Conceptualization, Methodology, Investigation, Data Curation, Formal Analysis, Writing – Original Draft, and Writing – Review & Editing: Mary Angeline de Dios. The author reviewed and approved the final manuscript and accepts responsibility for all aspects of the work.

## Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

## Conflict of Interest

The author declares no conflicts of interest.

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## REFERENCES

Alanazi, M. A., Shaban, M. M., Ramadan, O. M., Zaky, M. E., Mohammed, H. H., Amer, F. G., & Shaban, M. (2024). Navigating end-of-life decision-making in nursing: A systematic review of ethical challenges and palliative care practices. *BMC Nursing, 23*, Article 467. https://doi.org/10.1186/s12912-024-02087-5

Albert, R. H. (2017). End-of-life care: Managing common symptoms. *American Family Physician, 95*(6), 356–361. https://www.aafp.org/pubs/afp/issues/2017/0315/p356.html

Alshammari, F., Sim, J., McErlean, G., & Lapkin, S. (2023). Registered nurses' beliefs about end-of-life care: A mixed method study. *Nursing Open, 10*(12), 7796–7810. https://doi.org/10.1002/nop2.2027

American Nurses Association. (2025). *Code of ethics for nurses*. https://codeofethics.ana.org/provisions

Bajaj, K., Meguerdichian, M., Thoma, B., Huang, S., Eppich, W., & Cheng, A. (2018). The PEARLS healthcare debriefing tool. *Academic Medicine, 93*(2), 336. https://doi.org/10.1097/ACM.0000000000002035

Blazeviciene, A., Newland, J., Civinskiene, V., & Beckstrand, R. (2017). Oncology nurses' perceptions of obstacles and role at end-of-life care: A cross-sectional survey. *BMC Palliative Care, 16*, 74. https://doi.org/10.1186/s12904-017-0257-1

Cybulska, A. M., Zołnowska, M. A., Schneider-Matyka, D., Nowak, M., Starczewska, M., Grochans, S., & Cymbaluk-Płoska, A. (2022). Analysis of nurses' attitudes toward patient death. *International Journal of Environmental Research and Public Health, 19*(20), Article 13119. https://doi.org/10.3390/ijerph192013119

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48–71). Oxford University Press.

Crawford, G. B., Dzierżanowski, T., Hauser, K., Larkin, P., Luque-Blanco, A. I., Murphy, I., Puchalski, C. M., Ripamonti, C. I., & ESMO Guidelines Committee. (2021). Care of the adult cancer patient at the end of life: ESMO clinical practice guidelines. *ESMO Open, 6*(4), 100225. https://doi.org/10.1016/j.esmoop.2021.100225

De Brasi, E. L., Giannetta, N., Ercolani, S., Gandini, E. L. M., Moranda, D., Villa, G., & Manara, D. F. (2021). Nurses' moral distress in end-of-life care: A qualitative study. *Nursing Ethics, 28*(5), 614–627. https://doi.org/10.1177/0969733020964859

De Swardt, M., Krause, R., & Jenkins, L. S. (2024). How to approach patients and families at the end of life. *South African Family Practice, 66*(1), a5916. https://doi.org/10.4102/safp.v66i1.5916

Du, J., An, Z., Wang, C., & Yu, L. (2024). Nurses' self-regulation after engaging in end-of-life conversations with patients with advanced cancer: A qualitative study. *BMC Nursing, 23*, Article 344. https://doi.org/10.1186/s12912-024-02016-6

Fink, R. M., Valenti, K. G., Kline, D. M., & Fischer, S. M. (2023). Reality of family caregiving for Hispanics with Alzheimer's disease and related dementias: A qualitative analysis. *Journal of Palliative Medicine, 26*(12), 1767–1775. https://doi.org/10.1089/jpm.2023.0008

Hare, E. C. (2025). Respiratory Distress Observation Scale and medication administration. *Critical Care Nurse, 45*(4), 63–67. https://doi.org/10.4037/ccn2025268

Jarrad, R. A., & Hammad, S. (2020). Oncology nurses' compassion fatigue, burnout, and compassion satisfaction. *Annals of General*

*Psychiatry, 19*, Article 22. https://doi.org/10.1186/s12991-020-00272-9

Jeong, M., Song, C., & Park, S. (2023). Implementation and evaluation of an end-of-life care education program for oncology nurses working in medical-surgical wards: A quasi-experimental study. *Heliyon, 9*(4), e14096. https://doi.org/10.1016/j.heliyon.2023.e14096

Kero, J., Koivisto, J.-M., Kuusisto, A., Kesonen, P., & Haavisto, E. (2024). Nursing interventions for dyspnoea management among inpatients with cancer in palliative care. *International Journal of Palliative Nursing, 30*(2), 87–98. https://doi.org/10.12968/ijpn.2024.30.2.87

Klein, C., Voss, R., Ostgathe, C., & Schildmann, J. A. (2023). Sedation in palliative care: A clinically oriented overview of guidelines and treatment recommendations. *Deutsches Ärzteblatt International, 120*, 235–242. https://doi.org/10.3238/arztebl.m2023.0034

Kostka, A. M., Borodzicz, A., & Krzemińska, S. A. (2021). Feelings and emotions of nurses related to dying and death of patients: A pilot study. *Psychology Research and Behavior Management, 14*, 705–717. https://doi.org/10.2147/PRBM.S311996

Kwon, S., Kim, M., & Choi, S. (2022). Ethical dilemmas and care actions in nurses providing palliative sedation. *Nursing Ethics, 29*(5), 1220–1230. https://doi.org/10.1177/09697330221105639

Lai, X., Wong, F., & Ching, S. (2018). The experience of caring for patients at the end-of-life stage in non-palliative care settings: A qualitative study. *BMC Palliative Care, 17*, Article 116. https://doi.org/10.1186/s12904-018-0372-7

Makowicz, D., Dziubaszewska, R., Makowicz, N., Barna, P., & Piekos, M. (2019). The attitude of nursing staff toward the death and dying of patients. *Nursing in the 21st Century, 18*(3), 68–74. https://doi.org/10.2478/pielxxiw-2019-0024

McParland, C., Johnston, B., Bahri, H. A., & Hamdan Alshehri, H. (2025). Spiritual and cultural influences on end-of-life care decision-making: A comparative analysis of the Arab Middle East and the United Kingdom. *Current Opinion in Supportive & Palliative Care, 19*(4), 242–247. https://doi.org/10.1097/SPC.0000000000000778

Mughal, A., & Evans, C. (2020). Views and experiences of nurses in providing end-of-life care to patients in an ED context: A qualitative systematic review. *Emergency Medicine Journal, 37*(5), 265–272. https://doi.org/10.1136/emermed-2018-208278

National Cancer Institute. (2021). *End-of-life care for people who have cancer*. https://www.cancer.gov/about-cancer/advanced-cancer/care-choices/care-fact-sheet

National Coalition for Hospice and Palliative Care. (2025). *Care and comfort near the end of life*. https://www.nationalcoalitionhpc.org/care-and-comfort-near-the-end-of-life/

Neubauer, B. E., Witkop, C., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

O'Shea, E., & Mager, D. (2019). End-of-life nursing education: Enhancing nurse knowledge and attitudes. *Applied Nursing Research, 50*, 151197. https://doi.org/10.1016/j.apnr.2019.151197

Octaviano, E., Fernandez, R., Dionisio, A., Kuan, L., & Casanova, F. (2004). *Promulgation of the Code of Ethics for Registered Nurses*. Professional Regulation Commission, Board of Nursing. https://www.prc.gov.ph/sites/default/files/NURSING-CodeEthics-2004-220.pdf

Uzunkaya Oztoprak, P., & Terzioglu, F. (2024). Attitudes of oncology nurses towards care of dying patients and the principles of dying with dignity and their views on good death. *Omega: Journal of Death and Dying, 88*(3), 961–976. https://doi.org/10.1177/00302228211057743

Pinho-Reis, C., Sarmento, A., & Capelas, M. L. (2018). Nutrition and hydration in the end-of-life care: Ethical issues. *Acta Portuguesa de Nutrição*, (15), 36–40. https://doi.org/10.21011/apn.2018.1507

Polit, D. F., & Beck, C. T. (2018). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer.

Pun, J. K. H., Chow, J. C. H., Fok, L., Chan, E. A., Chiu, C., Lam, M., Cheung, T., & Chan, H. Y. L. (2023). Role of patients' family members in end-of-life communication: An integrative review. *BMJ Open, 13*, e067304. https://doi.org/10.1136/bmjopen-2022-067304

Rodgers, G. (2019). How do you deal with death and dying? *Clinical Journal of Oncology Nursing, 23*(3), 336. https://doi.org/10.1188/19.CJON.336

Semler, L. R., Robinson, E. M., Cremens, M. C., & Romain, F. (2025). An end-of-life ethics consult in the ICU: Who has the final say—The patient or the family? *Chest*. Advance online publication. https://doi.org/10.1016/j.chest.2024.10.028

Seo, N., & Yeom, H. (2022). Factors affecting psychological burnout in nurses caring for terminal cancer patients. *Journal of Hospice and Palliative Care, 25*(4), 159–168. https://doi.org/10.14475/jhpc.2022.25.4.159

Sung, H., Ferlay, J., Siegel, R. L., Laversanne, M., Soerjomataram, I., Jemal, A., & Bray, F. (2021). Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: A Cancer Journal for Clinicians, 71*(3), 209–249. https://doi.org/10.3322/caac.21660

Tagami, K., Chiu, S.-W., Kosugi, K., Ishiki, H., Hiratsuka, Y., Shimizu, M., Mori, M., Kubo, E.,

Ikari, T., Arakawa, S., Eto, T., Shimoda, M., Hirayama, H., Nishijima, K., Ouchi, K., Shimoi, T., Shigeno, T., Yamaguchi, T., Miyashita, M., Morita, T., Inoue, A., & Satomi, E. (2024). Cancer pain management in patients receiving inpatient specialized palliative care services: A multicenter study. *Journal of Pain and Symptom Management, 67*(1), 27–38.e1. https://doi.org/10.1016/j.jpainsymman.2023.09.015

Ulin, L., Knight, H., Lawton, A., Ramani, S., & Vise, A. (2023). *Debriefing challenging clinical encounters: The PAUSE framework*. Palliative Care Network of Wisconsin. https://www.mypcnow.org/fast-fact/debriefing-challenging-clinical-encounters-the-pause-framework/

Wilson, D. M., Bykowski, K. A., Banamwana, G., Bryenton, F. M., Dou, Q., & Errasti-Ibarrondo, B. (2025). Intra-family end-of-life conflict: Findings of a research investigation to identify its incidence, cause, and impact. *OMEGA—Journal of Death and Dying, 91*(1), 197–211.

Winzeler, L. (2020). *6 ways to cope with grief as an oncology nurse*. AMN Healthcare. https://www.amnhealthcare.com/blog/nursing/travel/6-ways-to-cope-with-grief-as-an-oncology-nurse/

Zahavi, D., & Martiny, K. (2019). Phenomenology in nursing studies: New perspectives. *International Journal of Nursing Studies, 93*, 155–162. https://doi.org/10.1016/j.ijnurstu.2019.01.014