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An Exploratory Qualitative Study of Oncology Nurses' Experience in Providing Care for Terminally Ill Patients in Salmaniya Medical Complex in Bahrain

Abstract

Oncology nurses are essential in palliative care for cancer patients, especially at end-of-life stages. Caring for terminally ill cancer patients is stressful, accompanied by negative and positive feelings, but oncology nurses have an unavoidable responsibility. However, little is known about oncology nurses' experience in the Kingdom of Bahrain caring for terminally ill cancer patients in their final weeks or days. This study aimed to explore the experience of oncology staff nurses in providing care for terminally ill patients in the Kingdom of Bahrain, and the research answered those questions: (a) What is the experience of oncology staff nurses in providing care for terminally ill patient? And (b) How does the experience of oncology nurses in providing care to terminally ill patients impact the quality of care provided to patients? A qualitative descriptive, interpretive exploratory research design was utilized for this study to explore the experience of oncology staff nurses with terminally ill patients, conducted in two hospital settings at Salmaniya medical complex (inpatient & outpatient) oncology department. The data were collected using a purposive sampling to include 15 oncologist nurses whose experiences were across various characteristics with different professional roles and qualifications. The data were collected through 15 semi-structured interviews guided by a semi-structured interview protocol. Data were analyzed using Braun and Clarke's 2006 thematic analysis model without pretexting. The research findings revealed three key themes that emerged from thematic analysis: (1) exhausting versus rewarding experienced feelings; (2) Factors influencing Nursing care; (3) Moral Distress. End-of-life care in the Kingdom of Bahrain reflects and has been influenced by primary total nursing care. Oncology nurses reported suffering but also benefiting from their experiences. End-of-life cancer care training is needed and urged by oncology nurses, especially those younger and less experienced. Also, future studies are mandated to explore interventions to help overcome the challenges that are impeding nurses from providing high-quality care for terminally ill patients in the kingdom of Bahrain.

Keywords

terminally ill, terminal care, palliative care, oncology nursing, qualitative research

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An Exploratory Qualitative Study of Oncology Nurses' Experience in Providing Care for Terminally Ill Patients in Salmaniya Medical Complex in Bahrain

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Oncology nurses are essential in palliative care for cancer patients, especially at end-of-life stages. Caring for terminally ill cancer patients is stressful, accompanied by negative and positive feelings, but oncology nurses have an unavoidable responsibility. However, little is known about oncology nurses' experience in the Kingdom of Bahrain caring for terminally ill cancer patients in their final weeks or days. This study aimed to explore the experience of oncology staff nurses in providing care for terminally ill patients in the Kingdom of Bahrain, and the research answered those questions: (a) What is the experience of oncology staff nurses in providing care for terminally ill patient? And (b) How does the experience of oncology nurses in providing care to terminally ill patients impact the quality of care provided to patients? A qualitative descriptive, interpretive exploratory research design was utilized for this study to explore the experience of oncology staff nurses with terminally ill patients, conducted in two hospital settings at Salmaniya medical complex (inpatient & outpatient) oncology department. The data were collected using a purposive sampling to include 15 oncologist nurses whose experiences were across various characteristics with different professional roles and qualifications. The data were collected through 15 semi-structured interviews guided by a semi-structured interview protocol. Data were analyzed using Braun and Clarke's 2006 thematic analysis model without pretexting. The research findings revealed three key themes that emerged from thematic analysis: (1) exhausting versus rewarding experienced feelings; (2) Factors influencing Nursing care; (3) Moral Distress. End-of-life care in the Kingdom of Bahrain reflects and has been influenced by primary total nursing care. Oncology nurses reported suffering but also benefiting from their experiences. End-of-life cancer care training is needed and urged by oncology nurses, especially those younger and less experienced. Also, future studies are mandated to explore interventions to help overcome the challenges that are impeding nurses from providing high-quality care for terminally ill patients in the kingdom of Bahrain.

Keywords: terminally ill, terminal care, palliative care, oncology nursing, qualitative research

Introduction

Cancer is a leading cause of death worldwide, accounting for nearly 10 million deaths in 2020 (Ferlay, 2021), and is the second leading cause of death globally (WHO, 2019).

Moreover, the number of deaths caused by cancer in the general population of Bahrain in 20 revealed that lung cancer caused 84 deaths, followed by breast cancer with 66 deaths. In addition, the number of deaths caused by cancer among women in Bahrain was 293 compared to 310 among men (Ferlay, 2021; WHO, 2021).

Oncology nurses are the ones who accompanied patients with cancer in both their good and bad times, from diagnosis to treatment/cure, or during palliative and end-of-life care, and thus they are the ones who most intimately witness what patients go through during this process (Güner et al., 2018). Nurses caring for terminally ill cancer patients experience challenges, despite aggressive efforts to reduce high death rates and extend the life of the patients (Frommelt, 2003). Press et al. (2009) viewed the effort of oncology nurses caring for terminally ill cancer patients as a complex issue, especially with elderly patients. Dehghan-Nayeri et al. (2018) explored factors affecting missed nursing care in oncology units and highlighted many factors affecting nurses' experience providing care for terminally ill patients such as staff shortages, time constraints, and repetitive and time-consuming jobs, thus, that subsequently affect the quality of care. Being a hospice nurse is a complex and multifaceted role with large amounts of complex emotional exposures (Broom et al., 2014; Seed & Walton, 2012). Work stressors in oncology units are often higher than in other units, as oncology nurses face challenges both within and outside the work environment that affect them negatively (Al Zoubi et al., 2020). Still, many hospice nurses are hesitant to talk about their own emotional experiences (Trier, 2006).

Previous research studies explored the experience and perspectives of dying patients with cancer (Bloomer et al., 2017). In contrast, the experiences of nursing professionals who care for terminally ill patients were less examined worldwide. Most of the published studies on healthcare professionals' experiences of palliative care have focused on the emotional well-being of specialist care team members (Tay & Hegney, 2012). Little data in the literature concerning emotions accompanying nurses while working with a dying patient is available. Additionally, only a few articles discuss strategies for coping with the emotions associated with death and dying patients (Kostka et al., 2021). Nurses' grief has not been sufficiently investigated in practice settings, it has been a well-recognized threat to health and work performance (Khalaf et al., 2017).

In the Kingdom of Bahrain, there are some studies related to cancer; meanwhile, there are no studies that reflect the experiences of oncology nurses with terminally ill patients. Therefore, this study explored the experiences of oncology nurses in providing care to terminally ill patients in context and the factors that affect the oncology nurses' experiences while caring for terminally ill patients.

Methodology

A qualitative descriptive, interpretive exploratory design (Merriam, 2002) was used because I aimed to describe and explore the experiences and practices of nurses caring for terminally ill cancer patients in the Kingdom of Bahrain at Salmaniya Medical Complex. Merriam (2002) emphasized that descriptive/interpretive designs used interchangeably to focus on how participants make meaning of situation or phenomenon, where the researcher describes the collective experiences and seeks to discover or understand the participants' point of view. Importantly, qualitative research concerns everyday human experiences in a natural environment (Maree, 2016). This study took place in Salmaniya Medical Complex in the Oncology Department (inpatient and outpatient units) in faith to fulfill research objectives and research questions.

Emphasizing the importance of ethical principles, ethical approval was obtained from the Scientific Research and Publication Committee at the University of Bahrain (UoB) with

referral code CHSS SRPC Recommendation No: 3/2021-22 dt. October 21, 2021. Additionally, ethical approval was gained from SMC Research & Research Ethics Committee for Government Hospitals, serial no: 12208112. And permission was taken from the nursing administration and the head nurse of the Oncology Department.

Before starting the data collection phase, I disseminated informed consent and participant sheet to the Nurse Supervisors of the Oncology Department. I asked participants to complete the required documents within 24 to 48 hours before participation in the study to ensure the willingness of staff nurses who meet the research requirements, and to confirm and declare their agreement or disagreement to participate in the study. The process of gaining consent consists of the following: consent should be given voluntarily, participants should understand what is being asked for, and involved persons must be competent participants to consent (Connelly, 2014). This refers to participating in a research study; participants need to be adequately informed about the research, comprehend the information, and have the power of freedom of choice to decide whether to participate or decline (Polit & Beck, 2012).

For this study, I employed a semi-structured interview for data collection to meet the aim and objectives of the study. Frey and Oishi (1995) defined the qualitative interview as a purposeful conversation in which one person asks prepared questions, and the other person answers with detailed, resounding, and nuance. Face-to-face individual interviews I held with oncology nurses in inpatient and outpatient settings. In my faith to explore participants' perception of end-of-life care, experience while providing care for terminally ill patients, and the impact of those patients on the quality of care provided by oncologist nurses.

In addition, I used an interview topic guide and protocol for a semi-structured interview to ensure the flexibility that allows modifying the order and details of how topics are to be covered and probe to direct conversation while maintaining the participants' narrative steer (See Table 1). The interviews ranged from 45-80 minutes with staff nurses in the spot of work setting. DiCicco-Bloom and Crabtree (2006) (2006) noted that interviews are often conducted only once, with an individual or a group, and generally last 30 minutes to more than an hour.

Table 1
Interview Questions

General Question	Probe Question
Background It would be nice if you could tell me a little bit about yourself: - How many years of experience as staff nurse/ and at oncology department? - What is your job designation?	
Work Experience Now we will talk about staff nurses experience: - what is the general experience of oncology staff nurses' in providing care for terminally ill patient at the end of their life?	- To how extent the difference in oncology nurse personal characteristics can affect the care of terminally ill patients? - What are the challenges the oncology nurses are facing while providing care of terminally ill patients?
Factors affecting care Are there factors affecting your care for terminally ill patients?	- To what extent the patient's clinical characteristics (age, gender, cancer stage, medical history, etc...) affecting the oncology nursing care to terminally ill patient?

	<ul style="list-style-type: none"> - To how extent the patients' sociodemographic characteristics (marital status, religious, educational level, etc...) affecting the experience of oncology staff nurses in providing care for terminally ill patients? - can you identify the social characteristics of terminally ill patients that affect the experience of oncology staff nurses? - detect the effect of clinical manifestations and disease features for each terminally ill patient on the experience of oncology nurse? - To what extent is the impact of family caregivers affecting the nursing care and treatment provided to terminally ill patients' care and treatment?
Communication skill Does oncology staff nurse own special communication skill?	<ul style="list-style-type: none"> - To how extent does the therapeutic communication used by oncology nurses affect the terminally ill patient's condition during receiving the care? - can you identify the effect of compassionate communication skill on the experience of oncology nurse with terminally ill patients,

Study Population

Fifteen nurses participated in the semi-structured interviews, as data saturation was achieved with the 15th interview. Mason (2010) pointed up the most scholars argue that the concept of saturation is the most vital factor to consider when mulling over sample size decisions in qualitative research. In qualitative research, saturation is used as a criterion for terminating data collection and analysis (Garrett et al., 2012; Lipworth et al., 2013). Saturation is the most frequently touted guarantee of qualitative rigour offered by authors (Morse, 2015).

Sample and Sampling Technique

I selected participants using purposeful sampling. Nurses working in oncology were purposefully selected as information-rich cases for in-depth study (Patton, 2002). Moreover, I recruited nurses from a local hospital with the goal of getting a diverse pool across Bahraini and non-Bahraini staff nurses from the oncology department with variation in their ages, educational backgrounds, years of experience, genders, working settings, and job designations. This diverse sample was selected to attain perceptiveness about their experience in the contexts of the study from various viewpoints.

Data Collection Methods

Qualitative data were generated through individual face-to-face in-depth semi-structured interviews with participants. A qualitative research interview attempts to understand the world from the participant's point of view, unfold the meaning of people's experiences, and

uncover their lived world; the main task in interviewing, therefore, is to understand the meaning of what the interviewees say (Kvale, 2012). The interviewing process seeks to cover both factual and meaning levels (Clausen, 2012).

Interviews were conducted in a private, calm room within an inpatient and outpatient setting after arrangements I made with the gatekeepers of the oncology department. Each interview session lasted approximately 45-80 minutes. I started the interview with general introductory questions to explore the participants' demographics, educational background, job designation, and general experience.

I recorded all interviews in the Integrated Circuit record (IC record); and registered a note for the participants' nonverbal cues, comments, facial expressions, and body language for further data analysis.

Data Analysis

I analyzed the data using Braun and Clarke's 2006 thematic analysis model described by Lochmiller (2021). I transcribed and documented the audio interviews in a verbatim form through Microsoft Word (2016) document immediately after the completion of each interview. In addition, initially I transcribed all interviews within 24-72 hours of interview time. I started the verbatim documentation by playing the audiotape and writing it in a Word document. I shared all interviews with the research supervisor (research team) to seek feedback and verification against the audiotape recordings.

The process of data analysis in thematic analysis, according to Braun and Clarke (2006), includes generating initial codes, defining and naming themes, reviewing themes, and searching for themes. I approached data in an interactive process; data analysis started earlier concurrently with the data collection process, which helped to see and make sense of integrated nonverbal cues for each participant.

Trustworthiness

As Polit and Beck (2012) reported, Lincoln and Guba developed four quality criteria for the trustworthiness of qualitative research: credibility, dependability, confirmability, and transferability.

Credibility is amplified through different strategies; I spent an average of six–eight weeks within the oncology department to engage with participants, interview protocol, and mattress tested at induction meetings with two research supervisors using the first interview as a pilot interview during the first supervisory meeting which held on before data collection. I shared an interview verbatim transcript with supervisors attached with field notes; to ensure the intactness of data collected and analyzed for initial codes, sub-categories, and themes. Transferability was ensured when I employed participants with distinctive features, e.g., different social backgrounds, educational qualifications, and variant years of experience in oncology departments and other departments (medical, surgical, and intensive care units), for transferring research findings to other care settings where health care provider delivers care for noncancer terminally ill patients. I supported this study by maintaining dependability through detailed information which illustrates the data collection method and data analysis process, also as limitations and obstacles faced throughout the research generating period. Confirmability was achieved before beginning the interviews with the participant, I established an approachable relationship to create an intact, comfortable, and trusting atmosphere, enabling me to collect data successfully; also, post each interview I summarized the conversation with the interviewees. Through the data analysis process, the supervisor advised me to analyze each interview individually with contentious debriefing and guidance.

Findings

Characteristics of the Study Participants

Qualitative data were obtained from 15 semi-structured interviews with 15 oncology nurses. The participants' working experience ranged from less than three years to more than 15 years, with a mean of 16 years. Their nationalities were ten Bahraini and five Indian staff nurses. Among the 15 participants, one was a male nurse. Participants had different positions, but most were ten specialist nurses with a mean age of 38.3 years. A summary of the participants' demographics (age, gender, nationality, position, and marital status), years of working experience, and highest qualifications obtained are presented in Table 2.

Table 2
Nurse Participants' Demographic Data

ID	Age	Sex	Position	NATIONALITY	Work Experience	Marital status	Educational Level
P1	45	F	Senior Nurse	Indian	18 Years	Married	Diploma
P2	47	F	Nurse Supervisor	Bahraini	25 Years	Married	MSN
P3	31	F	General Nurse Specialist	Bahraini	6 Years	Married	BSN
P4	40	F	Senior Nurse	Indian	18 Years	Married	Diploma
P5	51	F	Nurse Supervisor-Counselor	Bahraini	29 Years	Married	MSN
P6	42	F	Special Nurse Specialist	Bahraini	21 Years	Married	BSN
P7	33	F	General Nurse Specialist	Bahraini	9 Years	Married	BSN
P8	43	M	Senior Nurse	Indian	22 Years	Married	Diploma
P9	48	F	Senior Nurse	Indian	26 Years	Married	Diploma
P10	26	F	General Nurse Specialist	Bahraini	4 years	Married	BSN
P11	37	F	Senior Nurse	Bahraini	16 Years	Married	Diploma
P12	33	F	General Nurse Specialist	Bahraini	11 Years	Married	BSN
P13	29	F	General Nurse Specialist	Bahraini	7 Years	Single	BSN preparing for MSN
P14	39	F	General Nurse Specialist	Indian	18 Years	Married	MSN

P15	F	Special Nurse Specialist	Bahraini	10 Years	Single	MSN
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Notes. BSN = Bachelor of Science in Nursing; MSN = A Master of Science in Nursing

Three key themes about oncology nurses' experiences treating terminally ill patients emerged from the thematic analysis process: (1) exhausting versus rewarding experienced feelings; (2) Factors influencing Nursing care; (3) Moral Distress. Table 3 presents themes and subthemes.

Table 3
Summary of Themes and Subthemes

Themes	Subthemes
Exhausting versus rewarding experienced feelings	- Positive feeling - Negative feeling
Factors influencing nursing care	- Nurses' Characteristics - Patient Characteristics - Intra and interprofessional communication
Moral distress	- Inadequate Quality of care - Management Ethical issues

Exhausting Versus Rewarding Experienced Feelings

The first theme gained from analyzed data is the exhausting versus rewarding feeling that staff nurses face and experience while providing care for terminally ill patients. Emotional exhaustion occurs when a nurse experiences an excessively stressful situation leading to fatigue, being overwhelmed, and being emotionally drained. On the contrary, staff nurses' emotional rewards are expressed through acceptance, appreciation, respect, and satisfaction.

Positive Feelings

The analysis of the participants' verbatims verified that the participants reported positive feelings related to the nurses' practice, emotions, performance, and experiences while providing care for terminally ill patients.

Sympathy, compassion, and empathy arose in the participants' dialogues since the terminally ill patients remained hospitalized for an extended period and attached to staff nurses, predominating feelings resulting from this frequent contact with the patients, families, and team making them perceived as terminally ill patients as family members:

Because daily we contact and see the same patients... if they [terminally ill patients] will take chemotherapy session, they again will come after 21 days or two weeks to the ward for next chemotherapy session... frequent admission to the ward and frequent contact we fell like a family...We are like a family and community here [hospital]. Okay, that's a family community. (P1)

So, as a female when we are looking after lady's [female patient], we felt more empathetic to them. Because we think of ourselves in their place when they're crying for their children, we think of our children. If we are in her place, we

understand her [terminally ill patient] condition, we were showing too much empathy. (P4)

Patient being admitted for a prolonged period... we will use to them...some will ask for specific staff by name for help...we only like a family here [oncology ward]. (14)

Sympathy and emotional labor are the methods used by some participants to manage their feelings and expressions to achieve the dynamic requirements of working with terminally ill patients and staying emotionally detached. Also, specifically, some participants reported regulating their emotions during interactions with terminally ill patients, the nurse team, and supervisors:

But as soon as we cannot express our feelings like sympathy, no, we cannot show sympathy towards them [terminally ill patients]. We show everybody acceptance. (P9)

I will keep my emotional side even with my colleagues. I will keep my emotion side even if they are my friend ... in work setting, I will treat them as a nurse to patient or nurse to colleagues. (P3)

Self-development results from a contentious sense of a need for self-improvement initiated from continuum contact and attachment with terminally ill patients, which involves changing behavior, leading to progression that alters work skills, attitude, and daily social living. Some nurses verbalized self-development as a personality maturation, which means the impact of their experience with terminally ill patients made them more realistic about the nature and facts of life, so they became more mature, valuing the family, and beloved person. Viewing life as if there is nothing worth be upset about or to fight for. Furthermore, personality maturation, as described by other participants in the changes that caused an alteration of their personality and improved after they worked with the terminally ill patient; they became able to contact patients and give more care and love to family, friends, and beloved people.

The following quotes illustrate the participants' improvement and alteration:

I feel that much more mature now, valuing things valuing the people surrounding you, even the decision you will make; it won't be as fast as it was..., your faith will be more you know that you will not focus in little, little things... because we see that our patients live, they are going and leaving their family and loved ones. And being in that situation, you feel nothing more than this life, it's good. (P2)

When I see a patient dying and going... I think... nothing is worthy, I advise everyone to be happy not getting upset with anything. (P7)

My personality today differs than 14 years back, now I will not cry, I become very strong, I can face issues, I can take a decision. (P11)

Advising others to enjoy life even it helped me to change my life after working with the palliative patient I understood that we don't know what will happen the next day, so I want to be always calm and smile and give me the fullest to the daily life. (P1)

Moreover, the positive impact of working with terminally ill patients is described as the best course of action, which means throughout participants' experience with terminally ill patients let them provide a high quality of care, for good patient outcomes resulting in fulfilling patient wishes, pain-relieved, high quality of end-of-life treatment, and dignified death.

This perspective was shared by most participants:

I want to send the patient peacefully; I don't want them to suffer anymore. I don't want patients to feel pain. How to give the correct palliative care, support care, and urgent care? I want them to feel comfortable at their last moment. I don't want them to feel pain-free. (P3)

Palliative care, according to me means once cancer starts and it is the end of the life, we want them to prepare for a peaceful death. According to us, we want them to leave without any pain. And we want to give them a peaceful death. And we want their relatives also to accept what is going to happen. (P4)

But they need pain management to treat the pain first then psychological support spiritual support like a holistic approach or to view the family and the patient. (P9)

I think best management for dying patient is pain controlling, spiritual and psychological support by mullah or Quran, give patient whatever they want. (14)

I want them to feel like... I prepare the patient for their last days to stay at home. Personally, I prefer that because they want the family surrounding them, sometimes the idea of dying at the hospital makes more stress for this type of patient, I think they need emotional support from their family more than from us [nurses]. (P3)

Negative Feelings

Also, some participants considered that appreciation from terminally ill patients, their families, and work teams can give satisfaction. This satisfaction impacted them positively to be motivated more to give a high quality of care, even for the best course of action, as revealed by P6 and P8 in the following quotes: "I will feel relief if the patient or families smile and tell me thank you" (P6); "We expect from patient and family to understand we are under pressure" (P8).

Oncology work life takes up an essential place in staff nurses' life, which respectively influences their experience to be considered exhausted experience as described by research participants. Most nurses felt that caring for terminally ill cancer patients was emotionally demanding, strenuous, and stressful because of the extensive physical and psychological pain that patients experience. This was confirmed by participants who considered their experience exhausting when they felt emotionally drained. A heavy burden was left on them because this experience required physical, psychological, mental, and holistic care and effort by nurses for terminally ill patients, their families, and team members:

I will see the patient coming walking to take treatment, he will have treatment, he will have a tough time then he will recover... again he will collapse ...seeing

patient's journey he/she is going through and the upset event they faced and even their families it's it was a burden for us... really, and this is a burden. (P2)

It was very difficult because we are receiving a palliative care patient terminally ill patient and a very weak and every day there is the declaring of death. So, we all were mentally upset. (P4)

In the beginning, they will come walking and receiving chemotherapy and going back home happy with the hope of a cure. Then finally with late-stage disease progression, they will become unconscious, and they will die in front of us with that emotion in that situation that is very difficult for us to tolerate. Because as a nurse, we know emotional stability is a must for us. So, we will never cry in front of the patient. But going home, we will tell our family what happened. My heart is broken. (P4)

Caring for terminally ill and dying patients is a sensitive situation leading to tremendous anxiety for staff. The staff's feelings about death can also have an impact on how they deliver care. Thus, they were described as trapped in bad memories by participants. Ghosts of unforgettable memories negatively impacted participants, which handled this burden for several years.

Most participants expressed their intrusive thoughts or traumatic memories through these dialogues:

The impact is still there. I because you know this incident...I couldn't forget it because it's still I remember the face of that man who has to turn into flesh. I feel that: how you dare tell me that my kids cannot see my wife [husband of terminally ill patient], and he was like begging me, and I couldn't understand the importance of having family around the dying patients. (P2)

We have one patient... very beautiful and lovely, was in room 18... she is with breast cancer...during covid-19 she expired because she is neutropenic because of chemotherapy... till now if I will go that room I see her, her scarf, where she is setting. (P1)

Another negative impact of participant speeches is feeling or a sense of guilt. This sense arose when staff nurses could not provide the care that the terminally ill desired or fulfill their last wishes like meeting their family members or dying in the home surrounded by family and remaining pain-free:

I feel shy of myself... guilty... I put myself in his shoes, will I accept that? Totally no. And with my experience now year by year, I feel more guilty because I realize the importance of that... I cannot forgive myself. (P2)

Sens of guilt killing me... I did not accomplish patient last desire... she wants to see her small baby. (P12)

In addition, participants' words expressing their experience as exhausted are futile treatment opportunities. When staff nurses failed to deliver holistic, high-quality care to relieve the suffering of a terminally ill patient. Here, the opportunity for a cure is less, and supportive treatment care is appreciated: "In this stage, we need to give full support to patients, but

sometimes patients suddenly collapse because of pulmonary embolism, we feel like shocked and helpless we did not save the patient in proper time” (P14).

Burnout expression reflected the negative feelings participants experienced while providing care for terminally ill patients. The workload for participants dramatically expanded as more patients were required to be cared for beyond the standard nurse-to-patient ratios. Seeing terminally ill patients suffering and dying and participants being helpless generates the feeling of anger, compassionated fatigue, and burnout when the stress overwhelmed the participant. The nurses described their burnout as an outcome of their patients' emotional demands and poor prognosis and care outcomes.

Unfortunately, this burnout extent affects participants' family members, as some participants verbalized that:

If I will see the patient, especially he will be admitted into the ward for a long time. we would see him through the disease process when he was diagnosed and when he received the chemotherapy for example, and after that finally become very sick, I will feel really sad. And this may affect me till home, I'll tell my family what we face. (P7)

I controlled my emotion at work. I go home I get angry with my daughter and wife... seeing dying patient to much stressful, also less staff in the shift. (P8)

Participant verbalized their intolerance to seeing their patient who had a long disease journey dying and suffering in front of them:

But yes, between us, especially the patients who will be with us for a long time. We will know them we will know their family; we have...will have a fun time together. So, it's really difficult, especially when it's young patients. This is the most difficult for seeing young patients suffer suffering. Somebody surviving and somebody going. (P2)

I saw some of my colleagues, they will have like a personal relationship because sometimes patients with frequent admission will build a rapport with them [nurses] sometime this rapport will be very strong. Stuff some of them cannot tolerate the situation that the patient is dying. For example, He will be terminally ill, they cannot face it. So, I will see them collapse crying. They cannot face some of the nurses even they escape from the ward really escaping because they cannot confront the situation, or they cannot handle the emotions of the patient's family. (p2)

On the other hand, some participants lost their emotional stability and cried if their patient died as stated by some participants:

As human beings at the beginning, we couldn't separate it from our lives, we were carrying... these emotions even at home, I will feel sad for, example at the home my husband or my kids, they will feel it really ... Yes, I will take it to home. (P2)

And sometimes I really cry and with some patients, I will become too close with them close to their family, I will join them in their grieving days. (P7)

I remember I just cried once. About the patient, he was 15 years old, and he was a survivor of osteosarcoma when he was a child. So, after he was cured of osteosarcoma, he ... he developed AML [type of leukemia], and he was very sick. I didn't expect him he...will die, he was fine, just deteriorated suddenly. I didn't think that night that we will lose that patient and we lost him because of sepsis the complication of the disease itself. (P3)

It is found that some participants felt disappointed when their efforts and care are not appreciated by patients and their families. Despite this feeling, the nurse felt broken from the inside, but there was no choice other than to work for terminally ill patients, which affect the quality of care delivered to those patients:

I want to work in oncology, but not to give palliative patient care. At that time. I don't know what the oncology patient. So, all it was in my mind was that oncology patient with a cure. But what was the surprise when I came here (she means to work with terminally ill patients)? (P13)

A nurse participant denoted the negative impact and feeling they experience when providing care for terminally ill patients as narrated:

Have pain, I'll think I have the same as the patient's disease. (P10)

If we have pain in the abdomen, we will think of stomach cancer if there is any lymph node we will think of leukemia, like that the perception becomes, and even if any weight loss or any bowel movement changes we will think about having malignancies. (P4)

Factors Influencing Nursing Care

The nurses perceived terminally ill patient care to encompass addressing patients' physical and emotional needs. Nurses reported multiple factors and challenges they faced influencing nursing care and experience.

Nurse Characteristics

Nurses' age, gender, religious background, educational background, and training program they received affected participants' experience while dealing with terminally ill patients, as well as their motivation and desire to be recruited within the oncology department—moreover, their attitude, supportive role, obligations, and legislation:

I want to work in oncology, but not to give palliative patient care at that time. I don't know what is the oncology patient. So, all it was on my mind was that oncology patient with a cure. But what was the surprise when I came here [she means to work with terminally ill patients]? (P13)

We should be more empathetic, we should be modeling, we should be a good listener, and we should involve their families. And we will say we should be a mediator between the doctor and the patient. (P8)

I chose oncology based on patient and oncology Ward because so many Stuff they don't want to work here okay... Because of the situation... dealing with the cancer patient chemo, radiation terminally ill patient longest day it was difficult to see hematology cases, but I was happier that I will work in this area. (P11)

It is important to note that the educational level and participants' years of clinical experience five years and more impacted the quality of care provided to terminally ill patients and how they can play a crucial role, which helps enhance their experience with terminally ill patients. Participants mentioned that professional fulfillment was achieved through long years of experience, prolonged contact with terminally ill patients, and helping them cope with severe medical and social conditions. Moreover, nurses' educational background and perception of terminal illness affect the quality and safety of terminally ill patient care and explain the differences between experience and expertise among participants.

The participants' opinions on their years of experience are commented on and quoted:

I did my master's degree research with a palliative team, I like being there, also I can call it a golden day. We create a home visit program, and hotline services. (P2)

Actually, I'm working here now for 16 years, ... 14 years with oncology patients and two years at Accident Emergency. Actually, I made job training in the oncology ward where I am working recently... I am interested in palliative cases and caring for terminally ill patients since I was a student... (P11)

I tried surgical and medical, I prefer oncology because patients need us for help and support. (P1)

The master's degree holder participants defined well the terminally ill patients and explained their needs:

They are at the end stage, most of them stage four, and there is no cure. They are... they already received the first, second, and third line of chemotherapy, then they will shift the patient to palliative care [participants well defining terminally ill patient]. ... I wish to give them the best care. And I know that they will not live long. So, from my side, I will try my best to give them good care. (P13)

The terminally ill patients, for me, are of two different types. The first type is fully aware once they are at the terminal cancer stage and then they are having no other solutions. And the other type that they are not aware that they are terminally ill, and they are critical in critical condition. (P15)

Terminally ill patients, first of all, they will be diagnosed, they will get a treatment option such as the first-line treatment, second-line treatment, and third-line treatment, which is not treating the disease, but relieving the signs and symptoms of the disease and keeping them [terminally ill patients] as much as comfortable from the signs and symptoms of the disease. Actually, we're sorry to say that till the end of their life. (P7)

Intra and Interprofessional Communication

The importance of communication is a fundamental element in diagnosis, treatment procedures, and care delivery for terminally ill patients. It is a pivotal element in preventing misunderstandings in communication between patients, their families, and nurses during clinical encounters, which are described as interprofessional communication, also, between the oncology nursing team members described as interprofessional:

Communications has a big role in providing care, some patients they will... they will feel better if you will explain the procedure... some patients will say: no, I don't want you to explain, proceed with the procedure. So, I feel it's better to communicate with the patient. (P3)

I believe that the main thing that the nurse has characteristic she should be or he is carrying communication skills. It is very, very, very important. I think this is the key to each problem. Each obstacle of raising or building patient trust, and trustful relationship. Communication is a cornerstone of palliative care, besides the staff nurse she should be full of energy. (P16)

Patients' Characteristics

One of the most important issues that arose during data analysis are terminally ill patients' characteristics and their needs; described as demographic data (age, gender, educational level, ethnic group, socioeconomic status, etc.), as well behavioral status changes and mental status, several dialogues of participants expressing those changes:

Working with terminally ill patients, especially cancer patients, it's not easy, it is very difficult, especially if the patient is younger. Recently we were having one patient I think with 42 years old she was metastatic colon cancer and she was admitted for palliative care. So, most of the difficult part is the ... that... I mean... we are feeling like we will give only palliative care and supportive care, we cannot give any active treatment to her. So, it is a little bit difficult to deal with the patient. (P10)

Sometimes the patient themselves for their own cultural diversity, or whatever it is, they have a lot of restrictions of accepting the care from the healthcare provider, this might cause a conflict. Especially for the male and females in our culture [Arabic – Muslim culture]. If you want to provide a supportive touch, even if you were wearing gloves the patient themselves, they will not accept it. (P15)

Educated patients, are accepting whatever the doctor saying, and planning. But uneducated patients, they are not getting that much knowledge, even if we are telling them, it is cancer in addition to the doctor's explanation they're not getting that much knowledge. (P8)

The third theme that emerged during data analysis is moral distress, which will be discussed through three subthemes.

Moral Distress

Participants exhibited and expressed psychological discomfort and inability to complete what they believe to be an ethically responsible action due to internal or external factors such as emotions, feelings, beliefs, and personal and professional restrictions.

Inadequate Quality of Care

Lack of knowledge about cancer terminal stage and terminally ill patients' needs, lack of education and training program, oncology setting (in/ outpatients), and workforce shortage impacted nurse participants negatively to place them in a conflict between proper ethical practice and low patient health outcomes:

I worked four years with oncology patients... I did not receive any training... only small lectures... So it's better to have palliative or chemotherapy installation training before joining the oncology unit... it is better to have training before that ... (P14)

I just received some type of lecture from a counselor and or any other senior colleagues, and the experience I got from working with doctors, but I wish I could get the chance to study something official for terminally ill oncology patients. (P3)

I think all of us [nursing team] need to go for courses or small studies to improve our professional professionalism with the patient and with the relative. (P3)

Family Caregiver Role

Family members, close friends, and relatives can take the role of support for terminally ill patients along with health care providers. Providing a sense of support can enhance patients' health conditions leading to the best outcomes. On the contrary, the family's attitude (e.g., blaming, dissatisfaction, denying, etc.), perceptions, hiding the truth, or making the decision instead of the patient cause moral distress:

The palliative doctors... when they come and they will write the medications for pain relief, but sometimes we are not able to give that medication because some relatives they will tell she's sleeping always don't give her medications [narcotic or sedative pain killer drug]. (P4)

There was a patient with prostate cancer... admitted for chemotherapy. His son stressing on us, please do not tell my father you will give him chemotherapy, or he has cancer. (P1)

Management Ethical Issues

In addition, hospital policies form restrictions and limited legislation, e.g., the "do not resuscitate policy," is prohibited in the Islamic religion, and hospital role and regulation. Therefore, encouraged the practice of pulmonary resuscitation for terminally ill patients with multiorgan dysfunction, which caused a conflict between the nurse's role and sense of humanity for a dignified death. Also, hospital policy prohibited nurses from disclosing information to

patients and their relatives, causing miscommunication and trust issues. Thus, that extended to a lack of chemotherapy or some medicine:

I mean, I told you regarding CPR (cardiopulmonary resuscitation) and all these things, aaaa, like for us, we don't have like DNR (do not resuscitate) in our hospital, I told you about that guy (son of the terminally ill patients), he said: don't call CPR for my father because it's his life, but me as staff nurse I don't have anything officially for DNR. So, me, as a nurse, I will be questioned in case I will not call CPR. At the same time, they have wished for DNR. But me as a nurse and because of the hospital policy, I must call and activate the CPR for his father, so we did not fulfill the patient and his family's desire for the last moment. (P13)

So, we should obey the policies and procedures of that particular hospital and how they are dealing according to their policy, how they are revealing bad news or breaking bad news into the patient and their relative. Fortunately, doctors are disclosing all these things, and sometimes they will ask a close family member to go to the oncology clinic, and they will explain from there. When the relatives come back to us, it's very difficult to face them because they will come and ask us: sister, nothing can be done? (P4)

Discussion

I held the Discussion for this research respectively to compare the nurse experience with terminally ill patients in Salmaniya Medical Complex with current literature. And to find the similarities and disparities in inexperience.

Three main themes emerged from the data analysis. The first theme that will be discussed is "exhausting versus rewarding experienced feelings." These included two subthemes, positive feelings, and negative feelings. The second explained "factors influencing Nursing care," which included three sub-categories, nurse characteristics, Intra and Interprofessional Communication, and patient characteristics. The last theme derived is explaining "moral distress" experienced by nurse participants, which contained three sub-categories, inadequate quality of care, family caregiver role, and management of ethical issues.

Exhausting Versus Rewarding Experienced Feelings

The present study findings illustrated those nurses working with terminally ill patients experienced emotional challenges from their prolonged and daily exposure to suffering and death. Moreover, the nurses were emotionally challenged by describing their experience of being rewarded and positive feelings or exhausted and negative feeling; this aligned with de Carvalho Alencar et al. (2017) mirrored the nurses' feelings towards the terminal cancer patient during the confrontation routine work mandated an emotional involvement which described positive feelings related to the nurses' motivated and enhanced performance for the patient with cancer under palliative, and negative feelings of impotence and frustration influencing terminal care management.

Negative feelings/ exhausted feelings revealed in this study were expressed through anxiety, compassionated fatigue, and dissatisfaction. Bekelman et al. (2016) agreed with this finding and highlighted that the suffering and death of a cancer patient could bring up many anxieties for oncology staff and lead to developing emotional labor and compassion fatigue

which subsequently impacted the quality of delivered care. Beck (2011) emphasized that compassion fatigue was present in 25% of medical nurses and 78% of palliative care nurses.

Factors Influencing Nursing Care

Research participants professionally encountered terminally ill patients with several challenging factors that affected the quality of End-of-Life care provided. Those factors peered with the participants' demographic data, such as gender, educational background, year of experience, marital status, and age. Hurteau (2019) emphasized that healthcare agencies and academic institutions provide valuable insights into how certain nurses' demographics (age, gender, nursing experience, and others) influence nurses' attitudes toward caring for dead and cancer-dying patients, the older registered nurses with more experience tended to have more positive attitudes toward death and cancer-dying patients.

Research findings identified the participants' role in providing physical, psychological, and spiritual support factors influencing participants' experiences. Haavisto et al. (2021) also mentioned this result similarly, who revealed that oncologist nurses described the competence required for end-of-life care as physical support and an organized environment rather than offering mental or spiritual support. Conversely, Iani et al. (2020) showed that psychological symptoms are controlled through individualized, narrative psychotherapy to reduce psychosocial and existential distress and promote dignity, meaning, and hope in end-of-life cancer patients.

Terminally ill patients possess factors and characteristics that can influence participants' experiences; these research findings reflected that young age terminally ill patients made them more empathic about losing their life without fulfilling their wishes. A study conducted by Grech et al. (2018) explored nurses' experiences in providing End-of-Life (EoL) care to patients with hematologic malignancies. The study revealed that providing nursing care at the EoL was perceived to be particularly challenging with younger patients or their family members.

Kautzky-Willer (2014) mirrored that gender sensitivity has become a fundamental goal in preference-based medicine and cancer patient care, consistent with this study. Ullrich et al. (2019) suggested that a patient's gender is perceived to affect coping responses to physical and psychological burdens during palliative care. Female patients were described as using more expressive strategies to respond to their illness, such as sharing feelings and having more abilities to acknowledge their situation. Also, neglecting gender differences might prevent patients from finding a subjective way of coping with their illnesses. This research's findings which showed the impact of terminally ill patients' gender on research participants' experience, it seemed female patients are more demanding and seek more attention and care rather than males, and this restricted the quality of emotional and psychological support provided by female staff to male patients and vice versa in obedience to religious and cultural boundaries. Previous studies were in line with findings.

Participants in this study found themselves restricted by the terminally ill patient religious and social background (Castaneda & Scanlan, 2014; Karatay et al., 2016); Asian Americans, African Americans, Latinos, and Muslims cancer patients reported that the quality of their care was diminished because of their ethnicity or race. Similarly, Periyakoil et al. (2016) revealed that cultural beliefs and practices are particularly significant in cancer patients' experiences of suffering. Yet, palliative nurses often poorly understand them, mainly when their backgrounds differ from their patients.

Interestingly, interprofessional and interprofessional communication factors influenced nursing care for terminally ill patients. Research participants emphasized communication skills and their importance in building professional and trustful relationships with the nursing team,

cancer patients, and their families. Successful communication is described as effective communication. Meanwhile, miscommunication was explained as a language barrier, misunderstanding of body language, and limited-restricted conversation. Aligning with those findings, Clark (2017) emphasized that nurses need to focus on the current situation, listen carefully to the patient, and observe gestures and expressions instead of just performing caring procedures. Merlane and Booth (2020) concludes that the importance of communication with terminally ill cancer patients has shown an extreme need for open-honest communication, involvement in decisions about their care, and close monitoring with a regular assessment to allow them to cope with the instability of their condition.

Moral Distress

The research findings revealed that nurse participants experienced moral distress in response to different causative factors described in research findings as three sub-categories: inadequate quality of care, family role as caregivers, and management of ethical issues. The inadequate quality of care was uncovered in the research findings.

The oncology care setting (inpatient/outpatient) affected participant quality of care delivered, creating a gap, or limiting the nurse's ability to provide proper care, communication, and support. Aligning with this finding, Suhonen et al. (2018) conclude that nurses prioritized patient care or participated in the decision-making at the bedside and in the oncology unit.

A significant finding showed the shortage of human resources (nurses and assistant nurses), the intensive work shifts, and consequent fatigue as barriers to nursing presence. Mojarad et al. (2019) emphasized these findings through a qualitative study that aimed to identify the barriers to the nursing presence in oncology care units, which revealed dissatisfaction and demotivation to work in the oncology unit due to a shortage of nurses is not enough, shortage of assistant nurses forces the trained nurses to do non-specialized work such as transportation of patients, and this leaves them no time to spend with patients. The lack of education and training programs to prepare nurses working in oncology and palliative settings caused participants to provide inadequate quality of care. Kgosana et al. (2019) have also emphasized the identified need for oncology nurses for psychological support arises to help them deal with the emotional challenges they come across when providing care to patients with cancer because oncology care is a specialized subset of nursing; it requires a correspondingly higher level of training and education.

According to this study, family was found to play a significant role as caregivers during the disease progression of terminally ill patients. Their role as caregivers was considered one of the factors that may cause moral distress for nurse participants. The represented family members of dying patients have not infrequently reported unmet needs regarding their needs for information about their relative's changing condition, the process of dying, how symptoms would be managed, and what to do at the time of death (Clark, 2017). This also aligned with Bush et al. (2017), who noted that terminally cancer patients' families have also identified their own needs for emotional and practical support over the time their family member died.

Additionally, communication between family caregivers and the health care team should continue throughout the care plan. It should include information about the treatment goals, patient care plans, and what to expect over time (NCI, 2021). Traboulssi et al. (2022) reflected the cultural beliefs and impacts of knowledge deficits amongst Bahraini families and Arab region that influenced the way spouses and their wives perceived cancer and dealt with it. Also, their research result showed that participant's culture led them to view cancer as incurable and as a death sentence, and it was associated with a negative stigma in society, consequently participants and their families hiding the truth about diagnosis.

Nurse participants in this study explained a set of organizational factors affecting their experience, such as a lack of chemotherapy agents that delay a patient treatment cycle, maintain the stability of disease progression, or control some physical suffering, and hospital policy to do cardiopulmonary resuscitation (CPR) for dying terminally ill patients. Thus, those organizational factors came against staff nurses' morals, placing them in conflict and distress. Nwozichi and Ojewole (2015) and Willard and Luker (2007) also indicated that support from healthcare organizations and nursing administration could act as a buffer to decrease work stress and is health-protective for oncology nurses. A qualitative, descriptive, and explorative study conducted by Pettersson et al. (2020) revealed the ethics of "Do Not Resuscitate"- (DNR) -decisions in oncology and hematology care based on 287 free-text comments in a study-specific questionnaire showed that DNR decisions in oncology and hematology care gave rise to ethical considerations, crucial ethical values explained by the participants were to avoid harming to patients and to secure a peaceful and "natural" death with dignity for their dying patients; a preference for the statement "allows for natural death" instead of the traditional term "do not resuscitate" was found in the material. This emphasized participants' opinion to not resuscitate a terminal cancer patient who is dying but against SMC rules and regulations.

Recommendations

The research findings emphasize the need for effective training of nurses either pre-recruitment in oncology units, or for newly joined oncology units or even senior staff nurses. In faith to provide expert oncology nursing care for cancer patients and specifically for those with terminal stage developing and implementing innovative interventions and strategies to enhance oncology nursing education and training in end of life period.

Future studies encourage exploring interventions to help overwhelmed the challenges and obstacles that are impeding nurses from providing high-quality oncology nursing care in the hospital setting for terminally ill patients.

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