

Nurses' perception of the oncology patient's death: a qualitative study

La percezione degli infermieri della morte del paziente oncologico: uno studio qualitativo

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Background: Il tema della morte è uno dei fondamentali problemi con cui gli infermieri si possono confrontare nell'agire professionale ed al quale difficilmente si è profondamente e sinceramente preparati. Le difficoltà nel gestire il carico emotivo possono indurlo a sviluppare sentimenti negativi nei confronti della vita e, nella pratica clinica tali da influenzare le capacità di caregiving e la qualità delle cure fornite.

OBIETTIVO: esplorare le percezioni dell'infermiere di fronte alla morte del paziente degente nei reparti di oncologia.

METODO: Studio qualitativo fenomenologico. Il campione di infermieri è stato reclutato presso un I.R.C.C.S. di Roma, un Hospice di Latina ed uno di Rieti. I dati sono stati raccolti mediante focus group. Le interviste semi-strutturate caratterizzate da tre domande costruite ad hoc, audio-registrate, sono state poi trascritte ed analizzate utilizzando il framework analysis approach.

RISULTATI: sono stati condotti in totale 7 focus group con una partecipazione in totale di 39 infermieri. Dall'analisi qualitativa sono emersi quattro temi: "I diversi significati della morte", "Lo strappo della morte", "Le variabili percettive della morte", "Le richieste di aiuto".

CONCLUSIONI: Lo studio ha evidenziato la necessità di fornire al personale infermieristico un importante supporto psicologico ed emotivo, e di porre attenzione agli elementi organizzativi-ambientali per una migliore gestione dell'evento morte in oncologia.

PAROLE CHIAVE: Infermiere, fine vita, morte, paziente oncologico, studio qualitativo, cure palliative, psicooncologia

ABSTRACT

BACKGROUND: Death is one of the basic theme with which nurses are faced, and for which it is hard for them to prepare deeply and sincerely.

The difficulties in handling the emotional burden can cause them to develop negative feelings towards life and clinical practice, so that it affects their caregiving capacity and the quality of care provided.

AIM: To explore nurses' perceptions facing the death of a hospitalized oncology patient.

METHODS: Qualitative phenomenological study. The sample of nurses was recruited at IRCCS (Scientific Institute for Research and Healthcare) in Rome, a hospice in Latina and a hospice in Rieti. The data were collected by means of focus groups. The semi-structured interviews featuring three guiding questions constructed for this purpose, were audio-recorded, transcribed, and then analyzed using the analysis framework approach.

RESULTS: In total 7 focus groups were conducted with a total participation of 39 nurses. Four themes emerged from the qualitative analysis: "The different meanings of death", "The rupture of death", "The perceptual variables of death", and "Requests for help".

CONCLUSION: The study highlighted the need to provide nurses with substantial psychological and emotional support, and give consideration to organizational and environmental factors for better management of the event of death in oncology.

KEY WORDS: Nurse, end of life, nurses perception, death, oncology patient, qualitative study, palliative care, psycho-oncology

INTRODUCTION

The World Health Organization reported more than 41 million deaths due to noncommunicable diseases (NCD) in 2016 alone, including more than 9 million deaths (22%) due to cancer.(Organization, 2016) In Europe, cancer causes 1.7 million deaths per year, i.e. 53.1% of total deaths(Organization, 2015).

These data underscore the need and importance for health systems to deliver care at the end of life (EOL) that is as effective as possible(Nia, Lehto, Ebadi, & Peyrovi, 2016) and is a close match to patients' preferences. The literature calls the EOL a period of time –hours, days, weeks or months– in which, from a medical point of view, it is assumed that the permanent cessation of functioning of the organism as a whole is approaching(Bernat, Culver, & Gert, 1981). In this phase of life, cancer patients tend to have a growing need for nursing comprehensive and compassionate care rather than health care(Ghaljeh, Rezaee, Imanigohari, & Rafati, 2019). To provide this care, given the sensitivity and uniqueness of the moment, nurses require psychological skills, flexibility, comprehensive knowledge of the symptoms and how to manage them, as well as high clinical and communication skills(Ellington, Clayton, Reblin, Donaldson, & Latimer, 2018) to enable them to become a guarantor of the exchange of information, also through the app(Gambalunga et al., 2021), between the patient, family and healthcare team involved in helping(Blaževičienė, Newland, Čivinskienė, & Beckstrand, 2017). Nurses play a fundamental role in which they are engaged as information brokers, supporters and/or advocates(Iacorossi et al., 2020). Several qualitative studies(Walker, 2020) have, in fact, reported that the care of patients in need of accompanying on the path to death requires long-term professional commitment(Dierckx de Casterlé, Denier, De Bal, & Gastmans, 2010) and high interpersonal clinical competence(Dierckx de Casterlé et al., 2010; Walker, 2020). In fact, a shortage of nurses specialized in cancer care can further facilitate the emergence of burnout, and/or job dissatisfaction(Elmore, Wright, & Paradis, 2018), as well as making it difficult to devote time to all the details required by the welfare aspects of cancer patients(Beckstrand, Collette, Callister, & Luthy, 2012).

To this must be added all the emotional concerns of patients and families, that often force nurses to confront painful situations(da Luz et al., 2015). For each activity there is always a “first time”, and the first time a nurse face a patient's death remains a memorable event(Anderson, Kent, & Owens, 2015), which has a strong impact on his/her professional and personal life(Iacorossi, Gambalunga, Molinaro, et al., 2019). Then, when the practitioner experiencing this event knows that patients prefer to live the last moments of life in their own home, and instead the most frequent place of death remains the hospital, the impact may be even more severe. The whole care of the person and their family network in the hospital setting is, indeed, very complex to implement, moreover, the work environment, still very fragmented in the organi-

zation of activities and limited in the time dedicated to care, does not facilitate a clinical care approach tailored to the patient's needs in the end-of-life phase(Funes, Moraes, Cunha, & Almeida, 2020). In addition, dealing closely with the pain/agony and death of a person is an act for which it is hard for nursing professionals to cope in a deep and sincere way. Their difficulties in managing the emotional burden can cause them to develop negative feelings towards life and their clinical work, which, in turn, could affect their caregiving capacity and the quality of care provided(Lu, Guo, & Liu, 2011; Nia et al., 2016). This increases, therefore, the risk of exhaustion and stress(Ghaljeh et al., 2019). However, in the literature there are only a few qualitative studies on the experience of nurses working in oncology hospital settings. Therefore, the aim of this study is to describe accurately the perceptions of nurses facing the death of hospitalized oncology patients.

METHODS

This is a descriptive qualitative study conducted at Medical Oncology and Hematology Units, at Scientific Institute for Research and Healthcare in Rome, at a hospice in Latina and at a hospice in Rieti. From these institutions were recruited duty nurses who, in their professional work, had experienced at least one death of a cancer patient for whom they were providing care. Sampling was appropriate(Merriam, 2015) to identify those cases that could provide most information and ensure sufficient personal experience of the phenomenon under study(Speziale, 2011). The sample size was defined by the principle of data saturation(Speziale, 2011). For information gathering, audio-recorded focus groups (FG) of participants were conducted. This technique facilitates the emergence of conscious and reflective responses of participants: interaction with other people on a subject that is part of the work routine enables them to explain their experience objectively and makes easier focusing on issues that are often taken for granted(Acocella, 2015). To stimulate conversation and encourage interaction between the different participants, three guiding questions were chosen by the research team (Table 1). At recruitment, the study objectives and the methods with the FG were explained to the nurses, and having obtained their agreement to the study, they were invited to meet in small groups in a quiet place, free from sources of interference.

Table 1: focus group guiding questions

1. Can you describe what the concept of death is for you?
2. Can you tell me how you experience the death of a cancer patient?
3. Can you provide any suggestions that may be of help to colleagues who experience this event?

The interviews were conducted on presence of a researcher / moderator, to moderate participant's conversation and collect information for the use of the research project, who had to examine the dynamics of the group's report and record reflections derived from non-verbal language. Both the moderator and the observer refrained from intervening in any way with opinions or personal impressions, in order not to affect the result. At the end of the interview participants were asked to add something on the topic they wanted, in order to guarantee their full freedom of expression. Once completed, verbatim transcripts were made of the FG; these were read in depth in order to capture the substantial aspects of the experience (Kübler-Ross, 2011), and analyzed using the Framework Analysis approach (Ritchie, Spencer, Bryman, & Burgess, 1994). This analysis required each FG to be read repeatedly in its entirety by two researchers independently (familiarization), in order to facilitate the identification of units of meaning to produce codes, and through successive comparisons and abstractions of categories (indexing). Next, through discussion with three other researchers, these categories were joined according to similarity of meaning to form themes (charting) to serve as a summary of the essential concepts of the experience expressed by participants.

Charts were used to map associations between themes and categories and to define the nature of the phenomenon (mapping and interpretation).

Ethical considerations

This research was considered by local ethics committee and deemed exempt. The study was reviewed and approved by the internal review board of the research group, which was the relevant cross-institutional committee responsible for assessing the methodological appropriateness and ethically of the study design. The study was carried out in accordance with the principles of the Helsinki Declaration. Participation in the study was strictly voluntary and nurses were informed about the objective of the study. Informed consent was obtained from study participants. Collected data were analyzed in order to maintain confidentiality, and to guarantee data rigour, in terms of the data.

RESULTS

A total of 7 FG were conducted (Table 2), with a duration between 28 and 47 minutes. The sample was composed of 38 nurses and one nurse coordinator, aged between 23 and 58 years (mean 40.5 years), predominantly female (74.4%) and with a three-year degree in nursing (61.5%) (Table 3).

Four themes emerged from the qualitative analysis: *"The different meanings of death"*, *"The rupture of death"*, *"The perceptual variables of death"*, and *"Requests for help"*. The themes that emerged from the analysis are presented as follows, including the most significant participant quotes.

1. The different meanings of death

In this theme nurses (N.) express death event in different ways. For some of them it means liberation: *"The death of the terminal patient who comes here is a liberation from a state of illness, a situation that is incapacitating from all points of view; the patient loses his dignity and autonomy, sees the effects of the disease on his body, and even people who take care of him observe these changes, as well as all the suffering. For this reason, I say that death is a sort of liberation, liberation from pain... so I think it should not be seen as something negative"* (N.1, FG4). *"I experience death of the cancer patient as a liberation. It will seem cynical but it is not so, at least in my opinion. We see all the sufferings, the doubts, the uncertainties, the despair, the frustration, the tiredness of patients and families and then when they die it is a liberation for them and also for us who shared all their states of mind"* (N.6, FG5). *Death is also a relief from suffering: "In general, a terminal person knows that he will certainly never be able to recover so it is the end of suffering, a relief for the patient..."* (N.2, FG4). For others, however, death is a natural event: *"It is the final phase of life... a natural event"* (N.4, FG5). *"We know that we are born, we grow up and die"* (N.1, FG5). It is a separation: *"The fact that it is a separation from a loved one, especially if he/she is a young person, a child, a young father or a young mother, it is very difficult to accept"* (N.4, FG4). *"... It is a total separation... complete separation... it's a moment of pain, suffering... it's just something bad... definitive separation..."* (N.2, FG6). It is, sometimes, the beginning of a new path: *"Today I see death as the beginning of everything, the rebirth, the return to the Father's house"* (N.5, FG5). *"Death is the end of a journey and perhaps the beginning of a new path"* (N.1, FG3).

Table 2: Focus Group distribution

	n. FG	n. participants
IRCCS Rome	2	12
Hospice Latina	3	16
Hospice Rieti	2	11

Table 3: Socio-demographic data

	N.	%
Nurse	38	97.4
Nurse Coordinator	1	2.6
Age (year)		
Range		23-58
Mean		40.5
Sex		
Male	10	25.6
Female	29	74.4
Education		
Bachelor's degree	24	61.5
University degree	10	25.6
Regional Diploma	5	12.8

2. The "rupture" of death

In this theme, the feelings and moods that nurses feel for their patients' death emerge. The first feeling that emerges clearly is one of physical suffering: "Stabbed" (N.2, FG7); "a moment of excruciating pain" (N.3, FG2); "one deep rupture" (N.1, FG3). There is a sense of impotence: "When they come, I already know they are doomed" (N.2, FG3); "... I do all this and they die?! Is all this really necessary?! [...] It seems that you work and work, but in the end it is as if you have done nothing..." (N.1, FG4). "... you feel stunned, as if to say 'all my strength, all the resources which I brought to give and I gave because I chose to and...' and you feel helpless..." (N.3, FG2). There is frustration: "...it is frustrating to know... you can open the door and ask 'How are you?' And they start crying so suddenly..." (N.1, FG7). They are pervaded by a feeling of loneliness: "...there is no one here" (N.2, FG7), and neglect "I feel... a little bit... you know...abandoned" (N.3, FG6).

A feeling of anguish is also reported: "There is no comfort" (N.2, FG4). "I prayed all day that he would not die with me...that he would not die with me..." (N.2, FG2). "A continuous thought, we think and think again, ...we take them all home! [...]...I have them all in my dreams, always, still" (N.1, FG1). "I do not understand this torment" (N.2, FG4). "You say, why should he suffer" (N.2, FG1). There is a sensation of coldness: "I am physically present but my spirit is not there... I'm cold, I'm frozen..." (N.3, FG6); and finally panic: "I came home with panic attacks" (N.1, FG6).

3. The perceptual variables of death

In this theme nurses express the variables that come into play when one of their patients die. Among these are work experience: "Naturally the experience makes you stronger" (N.3, FG1); "I think, however, partly my 'detachment' is also due to the fact that I still have little experience..." (N.2, FG5). "It depends on the beliefs we do have, and that I have developed over time... it is therefore also experience that helps us" (N.5, FG5). Another is their professionalism: "...to know that I have done my job well is a valuable help for me to deal with the death of the patient" (N.2, FG2). "...I think about doing my job well and then I try to avoid further suffering and pain by accompanying them to death gently and alleviating their pain, and then I experience serenity when I see the patient's face no longer suffering but relaxed, at peace" (N.3, FG3). Another factor is the age of the patient whom they are attending. "The age factor greatly affects how we face death...for an elderly patient it is more easily accepted because it is the natural path of things...with a young patient it is not like that..." (N.6, FG1). "I see death of an elderly patient as a natural path. But when a woman dies, a mother, a boy, at a young age, then I feel terrible ... it's painful" (N.3, FG6). "I saw death of young people of my age and I identified myself with them...I was troubled at first, I did not accept it. While death of an elderly patient is a natural event" (N.5, FG3). Another is the relationship established with the patient and his family. "But in some cases we cling to hope, in the case of the young patient or when it reminds us of one of our family members. Then a lot also depends on the relationship established with the patient and his/her family.

You get more attached to some people, and then in my case I'm sorry..." (N.3, FG4). "It depends on the type of patient and the family, on the relationship I have established with them. With some you get so confident that you could almost compare them to friends ... and then you are more involved and sadder when the time comes..." (N.1, FG3). "Sometimes you cry. And this depends on the relationship that has been established with the patients and with the family, or on the affinity that you find with the patient, because there is the perception that one is caring for one's own relative, a daughter, etc., and it happens that we get emotional and cry, because you do not get used to death" (N.2, FG7). A further factor is faith: "I find comfort in faith, I believe a lot, I have always believed in God and this helps me to face death and to accept it even when a young life is involved" (N.1, FG3). "I think the Lord, for some reason we do not know, wanted one of his sons to return to his father's house early" (N.1, FG6).

4. The requests for help

This theme identifies all the supports that nurses consider necessary to manage and experience the death event of the cancer patient in the best possible way. First of all, the necessity of the presence of family members is identified. "Leave [the patient] with loved ones" (N.1, FG3). "Perhaps welcoming family members" (N.2, FG3). "We always put in another bed for a relative, yes...both night and day...and they have free entry...at any time..." (N.4, FG1). There is the need for more suitable environments: "A double room, for me, is very ugly...to have a dying person next to you, or a person in chemotherapy. Maybe he has the same pathology...It's very bad and somehow we have to solve it ..." (N.1, FG3). "Investment in the end of life phases have poor returns, so that makes institutions invest very little ... there is no room where you can talk about the end of life, there is no separate room for a patient who is dying, people are mixed together..." (N.2, FG2). "An armchair that maybe you make them sit in ... in short ... so, just sitting on a chair, or in the corridor... it goes to your heart..." (N.1, FG3). There is also a need for a better allocation of nursing staff within the various operating units. "An interview before assignment to the ward" (N.3, FG4). "Evaluation before putting a person to work in oncology" (N.3, FG4), (N.1, FG4). Also, a need for better basic training about death event: "We were not taught during the course... you should be taught certain things..." (N.2, FG6); and more time to dedicate to the patient: "There is not even time to digest it" (N.3, FG2); "I need to talk to the patient, I have to talk to him! But unfortunately I have my time cut back to a minimum... so I cannot even speak as I go past their beds, because I have to run like crazy..." (N.3, FG2).

Nurses ask for more clarity in explaining the disease to patients and family members. "There is little clarity in anything" (N.2, FG2). "But am I dying?!" Nobody says it... nobody is able to tell patient the truth... I remember now, a patient asked recently: 'But how am I?' 'Er, now, let's try to...' and he died that afternoon... that is, no one was able to tell him anything... nobody... neither the doctors, nor the nurses, nor the head nurse... no one..." (N.1, FG3). They also ask

for wider use of sedation. *“Also the accompaniment, the pain, when they are finding it hard to breathe... many times yes, many times they are not assisted... I don’t mean by us, eh, but in the pharmacological sense...”* (N.1, FG2). *“I would like them to be treated in a timely manner”* (N.2, FG4). *“The only suggestion is that... maybe sedate them a little bit more... do not bring them to the point of complete exhaustion...”* (N.2, FG 3). *“As if you get used to it... you can see that sooner or later... there is that sweet passage...”* (N.2, FG3).

The presence of a psychologist in the department and psychological support is also important for the patient and/or family members. *“When they have... the conversation with the doctor, to give it a more acceptable character... it should also be done by the psychologist...”* (N.3, FG5). *“To have the psychologist there at the start... To know that if needed, there is someone who can help them is different from saying ‘Look, can I see you a moment outside’...”* (N.3, FG1). *“It would take away a considerable emotional burden if there was someone else shouldering that part... we could focus only on the deceased patient...”* (N.3, FG1). A psychologist is also important to evaluate the emotional impact on the operators. *“It’s all cut down to the bone... you are called to be a nurse, you also have to provide therapy... in the end, the psychological aspect of your health, that is, if you have had all you can take, where you can go to unburden yourself, that does not interest anyone...”* (N.3, FG2). *“In radiology you have platelets, but for us, who evaluates us psychologically?!”* (N.2, FG2).

DISCUSSION

The aim of this study was to describe the perceptions of nurses facing the death of the hospitalized oncology patients.

The interviews revealed how nurses give the oncology patient’s death different meanings ranging from a sense of liberation, and relief from suffering related to the disease, to considering it a natural occurrence common to everyone and, in some cases, the beginning a new path. The death event is, in fact, defined in literature as the permanent cessation of the functioning of the organism as a whole, an inevitable event often described as a natural process, or rather, as an event that separates the process of dying from the decomposition process of the organism (Bernat et al., 1981). Basically it represents the final phase of the natural cycle of life that begins at birth. The death event is considered natural by our sample of nurses interviewed, when involves elderly patients. But if it involves the death of a young child (Montgomery, Sawin, & Hendricks-Ferguson, 2017), the rules of nature seem subverted, and the experience has a psychological and physical impact both on patient families and on operators who are called to assist. One study, in fact, found that nurses working in settings where the death event often occurs in young patients are more prone to stress and/or emotional exhaustion (Redinbaugh, Schuerger, Weiss, Brufsky, & Arnold, 2001). Regardless of the way they deal with this event, nurses recognize the presence of an emotional impact in taking care of patients in EOL, which is extremely challenging

and very difficult to sustain (Broom et al., 2015). The negative feelings can be of impotence, frustration and anguish, to the point of experiencing real panic attacks. Some studies have, in fact, confirmed the presence of such feelings in nurses who care for terminally ill patients, these feelings are also generated by a lack of participation in the decision-making process on treatments to be implemented in the last moments of patients’ lives. The study suggests, moreover, that the way of experiencing the event of a patient’s death is strongly influenced by work experience and acquired professional skills. In general, each nurse attributes to the duration of their experience the possession of a greater inner strength that enables them to face patient’s death in a more bearable way. In fact, more senior nurses feel protected and strengthened by having a greater experience, while younger ones attributed to their own inexperience the ability to witness the patient’s death in a detached manner. The latter notion is in contrast with what is presented in the study of Zheng et al. (Zheng, Guo, Dong, & Owens, 2015), which showed that young nurses, because of a deep conflict between professional duty and their moral instinct, have greater emotional involvement in caring for cancer patients in EOL, compared to nurses with more clinical seniority. The only consolation for the nursing staff interviewed was their awareness of having done their job in the best possible way. Literature reports that in the contexts of care in EOL, nurses need to feel confident that they have provided a good level of care to patients, have done everything possible to guarantee their comfort fostered a feeling of serenity for them and their family, and supported them in dealing with the final phase of their life (De Bal, de Casterlé, De Beer, & Gastmans, 2006).

Nevertheless, the nurses surveyed reported a lack of knowledge and competence in EOL care that has an impact on work stress. This result is in agreement with other studies that suggest that nurses are rarely adequately educated on how to deal with the dying patient (Lu et al., 2011). The nursing literature recognizes, in fact, that the lack of information on assistance to patients who find themselves at this stage of the disease, is one of the main obstacles to the provision of quality care. A study by Hebert et al. of nurses involved in caring for EOL stage patients has shown that 71% of study participants lacked adequate knowledge about pain management, 62% lacked general knowledge of all EOL related problems, and 59% had inadequate knowledge on the management of symptoms related to the final phase of disease (Hebert, Moore, & Rooney, 2011). The lack of effective communication between staff, and with patients and their family is experienced by the interviewed nurses as particularly difficult to deal with (D’Angelo et al., 2012; Ellington et al., 2018). Death and dying are topics on which it is difficult to talk clearly and directly about with patients and their families, and this makes nurses’ work all the more difficult and emotional. Several studies report that in settings where the information about the state of the disease is given to patients and family evasively, overall nursing care is more complex (Iglesias, Pascual, & de Bengoa Vallejo, 2013).

Unclear communication is, in fact, recognized as one of the main obstacles to nursing care in the diagnostic and therapeutic process (Iglesias et al., 2013) both by nursing staff and by the patients themselves (Iacorossi, Gambalunga, De Domenico, et al., 2019; Iacorossi et al., 2016; Iacorossi et al., 2018).

The particular scope of cancer makes it difficult to mentor the acquisition of skills related to aspects of communication (Dahlin, 2015), and this causes nurses, especially in the final stages of the disease, to feel uncomfortable in establishing a conversation with patients about their health condition, or feel that they are not authorized by the oncologist to start it (Dahlin, 2015). In addition to that we must add the lack of suitable environments where the patient is assisted, staff shortages, and often the lack of time devoted to the patient. These elements, which depend in part on the lack of resources available to organize the work in the department, should be included in those stressors that, according to Raeda Abu al Rub (Raeda Abu Al Rub MSN, 2000) originate from organizational and environmental factors. In particular the lack of time available devoted to patients and their families is often recognized by nurses as an obstacle to the provision of quality care (De Bal et al., 2006) and, therefore, as an element that generates a deep sense of guilt (De Bal et al., 2006). At a time that is by definition so drastic, the relationship that is established between nurse, patients and families has a unique value, and often has a strong influence on the way they are able to deal with and to live through the entire welfare path (Dierckx de Casterlé et al., 2010). Nurse respondents describe it, in fact, as an emotional connection which, if strong, makes this time extremely painful and even heartbreaking. This time, because of its characteristics, requires the presence of a psychologist to give support to both staff and family members; but that, unfortunately, is often lacking. Nurses feel abandoned psychologically at a time that they are forced to live through repeatedly in their working lives, and also recognize the need for the patient's family to have support to help them to live through these moments better. As reported in literature, in fact, the lack of health care and quality psychological support during critical moments of life is a clearly recognized problem in both the US and Europe (Gjerberg, Lillemoen, Forde, & Pedersen, 2015; Iglesias et al., 2013).

Clinical implications

The increasing needs for EOL care, in different settings correspond to a growing attention to nursing education from as early as the undergraduate level (Iacorossi et al., 2020; Mastroianni et al., 2019; Notarnicola, Stievano, Barbarosa, et al., 2018; Notarnicola, Stievano, Pulimeno, et al., 2018). It is important to use evidence based education for health care providers and students to improved EOL management. It is therefore necessary to sensitize institutions to the need to organize courses to train nurses on death event management and to hold periodic meetings with the psycho-oncologist in order, share experience of all team members, and to acquire appropriate modes of

communication with the dying patient (Bumb, Keefe, Miller, & Overcash, 2017) and family members (Clayton et al., 2017). Moreover, it is important to support their autonomy, patients and family members must be given all the information necessary to make an informed decision and participate in their EOL care management (Sijabat, Dahlia, & Waluyo, 2019).

Study Limitations

One limitation of this study is the lack of a quantitative study to show the degree of objectivity in the results. Moreover, participant received the interview questions in advance and this may have resulted in unintentional self-censoring; however, those participants who did so stated that this helped them to formulate more in-depth responses. In this study, we chose to focus on the opinions of only nurses, however, the experiences of other healthcare providers.

CONCLUSIONS

The qualitative study highlighted the need for a considerable degree of psychological, emotional and organizational support for nurses practicing their profession in oncology, in order to improve the experience of facing the event of a patient's death. The recommendation for the future is to carry out a mixed-method study to improve understanding of nurses experience on this issue and suggest evidence to be used in clinical practice.

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