British Journal of Nursing Studies
ISSN: 2755-080X
DOI: 10.32996/bjns
Journal Homepage: www.al-kindipublisher.com/index.php/bjns

BJNS
AL-KINDI CENTER FOR RESEARCH AND DEVELOPMENT

| RESEARCH ARTICLE

Emergence of a Constructivist Theory on Nurses' Caring Decisions for Patients Being Withdrawn from Ventilatory Support

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| ABSTRACT
This research is centered on developing a constructivist grounded theory that reflects how intensive care unit (ICU) nurses carry out their caring decisions for patients withdrawn from ventilatory support as captured from the Filipino context. To frame an exhaustive discussion, the researcher utilized Charmaz's constructivist grounded theory approach with semi-structured interviews, observational field notes, and memos as data collection methods. Employing theoretical sampling, twenty senior ICU nurses, four doctors and ten patients' family members provided data that formulated the theory. The formulated core category of Perspicacity in Caring Decisions is indicated by ICU nurses' ability to develop a deeper concept of wisdom and understanding gained through clinical and life experiences. This constructivist theory stands on a strong foundation built from five interlinked subcategories: Voicing Out, Establishing realities, Navigating transitions, Taking the time, and Serving a Good Death. This brings together and contextualizes what was happening throughout the processes of nurses' end-of-life caring decisions. This research concludes that moving into a realm where death becomes an acceptable outcome, recognizing the Filipino cultural background, the patient made comfortable, and their family supported to understand the change of direction in approach are essential parts of the nurses' caring decisions.

| KEYWORDS

Caring Decisions, End-of-life care, Ethical decision making, Withdrawal of ventilatory support.

| ARTICLE INFORMATION

ACCEPTED: 02 February 2024 **PUBLISHED:** 01 March 2024 **DOI:** 10.32996/bjns.2024.4.1.4

1. Introduction

Intensive care units (ICU) in hospital settings have been known to provide progressively sophisticated and advanced treatments to patients with critical illness. Springing from this technophilic nature, the use of ventilatory support among ICU patients experiencing reversible critical illness may prove to be lifesaving or life-extending. However, when this life-extending intervention in the ICU is considered futile and unsuccessful or will only prolong the suffering of both patients and families, decisions have to be made regarding the withdrawal of ventilatory support (WDVS), which now constitutes end-of-life caring decisions.

A definition of end-of-life decision making was proposed by Thelin (2012) as the process that healthcare providers, patients, and their families go through when considering what treatments will or will not be used to treat a life-threatening illness. In the context of nurses, this becomes caring decisions (i.e. the combination of decision-making and caring processes) integrated with concepts of how the nurse can best provide care during an end-of-life situation.

Although ICU nurses play a focal role in facilitating WDVS, they are often excluded from such a process and are only seen as implementers. A range of authors suggests that nurses' lack of involvement in this process is a cause for concern, particularly as they often hold unique information regarding patients gathered during their constant bedside presence (Lai et al., 2018; Hov, Hedelin & Athlin, 2017). Despite this integral role, Filipino nurses face several challenges in carrying out caring decisions.

On top of these is the Filipino nurses' lack of adequate professional training or education to care for patients at the end-of-life and having no adequate resources available to guide their practice. In addition, hospice and palliative care are indicated as just an elective course in the Philippine nursing curriculum. The nurses' situation is even more compounded by the very few palliative care facilities in the country that facilitate the transition from a curative approach to end-of-life care (Manalo, 2017). It is not surprising, then, that Filipino nurses have reported difficulties in providing care for patients during end-of-life situations. The 2015 Quality of Death index has listed the Philippines as one of the worst places to die, scoring poorly in the quality of end-of-life care available (Economist Intelligence Unit Report as cited in Manalo, 2017).

In this context, ICU nurses have much to offer when it comes to philosophies underpinning end-of-life practices and changing the perception that death in this environment is not a failure but an opportunity to facilitate a good death. ICU nurses' 24-hour presence at a patient's bedside means their insight and input into end-of-life processes is invaluable and needs to be encouraged for the benefit of those who will die in the ICU. This research proposes that moving into a realm where death becomes an accepted outcome, recognizing the cultural background of Filipino families and nurses alike, the patient made comfortable, and their family supported to understand the change of direction in approach are essential parts of the nurses' caring decisions. How Filipino ICU nurses fit into the process is the area of research that this study tries to explain by developing a constructivist grounded theory using Charmaz' method.

2. Literature Review

End-of-life decision making in nursing is a complex and ethically challenging aspect of healthcare, involving considerations of patient autonomy, quality of life, and ethical principles (De Vries & Plaskota, 2017). Several forms of this decision making are possible, which include advance directives where patients can express their preferences in writing before a critical illness occurs and resuscitative measures decisions that may result in Do-Not-Resuscitate (DNR) orders.

In the context of this study, the decision-making process is focused on withdrawing ventilatory support. When decisions have been made to withdraw ventilatory support, a decision to pursue "comfort care" and facilitate good death may follow. Comfort care involves discontinuing any diagnostic or therapeutic procedures that do not contribute to the patient's comfort, as well as ensuring that adequate amounts of analgesics and sedatives are given to control pain, dyspnea, or other uncomfortable symptoms. In the study by Dobson (2017), 46% of 200 patients who died in one medical center had comfort care plans in place at the time of death.

Nurses play a vital role in facilitating these decisions, often serving as advocates for patients and their families. This explores current research and literature on end-of-life decision making in the nursing context, focusing on themes such as communication, ethical dilemmas, decision-making processes, and interventions to support patients and families.

Effective communication between healthcare providers, patients, and their families is crucial in end-of-life decision making. Research by Toles et al. (2018) emphasizes the importance of open and honest communication, acknowledging patients' preferences, values, and goals of care. Nurses who engage in empathetic communication can help patients and families navigate difficult decisions, leading to improved quality of care and greater satisfaction with end-of-life experiences (Kehl, 2021).

2.1. Ethical Dilemmas and Decision Making

End-of-life care often presents nurses with ethical dilemmas, such as balancing respect for patient autonomy with beneficence and non-maleficence. Studies by Robichaux & Clark (2016) highlight the ethical complexities involved in decision making, particularly regarding withholding or withdrawing life-sustaining treatments. Nurses must navigate these dilemmas while upholding ethical principles and advocating for patients' best interests.

One of the principles viewed as central to ethical decision making is autonomy. This calls for the patient to be the decision-maker. Persons have a right to put forward their end-of-life treatment preferences. This principle calls for healthcare providers to preserve the patient's right to self-determination even when the patient has lost decision-making capacity. This preservation can be achieved through the appropriate use of advance directives. Since, in most cases, advance directives are not in place, like in the case of the Philippines, healthcare providers frequently resort to patient surrogates to make ethical decisions in lieu of the patient. This action may be a violation of the principle of autonomy if the patient still has the decisional capacity or if the patient no longer has the decisional capacity and the decision maker is unaware of the patient's wishes (Ong et al., 2018).

In addition, spirituality is a central ethical theme for a patient near the end of life. Spirituality may span from the affirmation of specific religious beliefs to simply making sense or identifying meaning in life. Healthcare providers should explore whether the patient would value a visit from a clergy person and the importance of religious rituals to the patient. There is a need to facilitate available resources to aid their patients in spiritual care (Karnik & Kanekar, 2016).

Additionally, the ethical principle of beneficence calls for healthcare providers to advocate for what is good or beneficial for the patient. In cases when the patient's preferences are unidentified, the healthcare providers' role for the dying patient must always be to advocate for approaches that promote good care for the patient at the end of life. Healthcare providers need to be careful, though, that patient autonomy must not be violated in an attempt to do what they view as in the patient's best interest. Thus, patient autonomy should prevail over paternalism. (Welie & ten Have, 2014).

Another is the principle of non-maleficence, which calls for healthcare professionals not to inflict harm intentionally. Many health care providers believe that any omission of a life-sustaining treatment is tantamount to euthanasia or at least assistance in the patient's suicide, making it very difficult to withdraw a life-sustaining treatment (Welie & ten Have, 2014). However, if the health care team, after a careful assessment of the patient's condition and the patient's own goals and interests, is convinced that a particular life-sustaining treatment will do more harm than good, it should not attempt such treatment, even if the patient will surely die without. This should also be weighed against the use of expensive treatment in futile case circumstances with the current increase in healthcare costs. Hence, in the case of futile treatments, families and patients can ethically consider the option of comfort care (Karnik & Kanekar, 2016). However, this may be extra challenging for healthcare providers since the stewardship of limiting medical care is surrounded by other ethical issues, as the patients and their families do not understand the need to limit treatment in some cases where it is futile.

Moreover, the ethical principle of justice demands fairness in the delivery of healthcare. It may apply on a societal level by assuring a just distribution of healthcare resources, or it may apply to an individual patient by assuring fair treatment to that patient at the end of life. In either case, healthcare providers have an ethical obligation to advocate for fair and appropriate treatment of patients at the end of life (Karnik & Kanekar, 2016).

The last ethical principle, fidelity, requires the healthcare providers to be faithful and truthful to the dying patient and/or their families. Healthcare professionals should provide ongoing information about the patient's condition when appropriate to support the decision-making process (Karnik & Kanekar, 2016). Also, all those who are involved in patient care need to be truthful in issues such as diagnosis and prognosis and be faithful in defending the choices and decisions of the patient even when the patient can no longer speak for himself or herself.

Research by Baile et al. (2017) explores decision-making processes in end-of-life care, emphasizing the importance of shared decision making involving patients, families, and healthcare providers. Nurses play a pivotal role in facilitating these discussions, providing information, clarifying values, and supporting informed decision making. Collaborative decision making can lead to decisions that align with patients' preferences and values, enhancing the quality of end-of-life care.

2.2. Interventions to Support Patients and Families

Various interventions have been developed to support patients and families facing end-of-life decisions. Palliative care, for example, focuses on symptom management, psychosocial support, and advanced care planning (Lai et al., 2018). Nurses trained in palliative care can provide comprehensive support to patients and families, addressing physical, emotional, and spiritual needs throughout the end-of-life journey.

2.3. Synthesis

While ICU nurses are perceived as being integral to end-of-life decision-making and care, barriers are widespread regarding their consistent inclusion in the decision-making aspect of this process. End-of-life decision-making, end-of-life care, and nursing caring decisions have been critically reviewed. Literature has confirmed that in almost all parts of the globe, doctors are the only decision-maker, neglecting the role of nurses in such decisions. Because of this reality, nurses often experience dilemmas in making their caring decisions for patients. Literature also emphasized that this type of decision should be approached with a multidisciplinary perspective. In addition, reviewed literatures also highlighted that the ineffective training and absence of policies severely limit nurses' ability to deliver high quality care to patients and patients' families and to communicate effectively with the health care team, both of which contribute to heightened stress and burnout for critical care nurses. This is especially true in the Philippine context, where literature has revealed that ICU nurses do not have a direct role in hospital ethics committees where these decisions are commonly made.

More importantly, the constant presence of ICU nurses at a patient's bedside means their insight and input into end-of-life processes is invaluable and needs to be encouraged for the benefit of those who will die in the ICU. Therefore, this researcher proposed that moving into a realm where dying becomes an accepted outcome, recognizing the cultural background of Filipino families and nurses alike, the patient made comfortable and their family supported to understand the change of direction in approach is an important part of the nurses' caring decisions. How Filipino ICU nurse's fit into the process is the area of research that this study tried to explain by developing a constructivist grounded theory using Charmaz' method. This theory would be

instrumental to springboard an initiative supporting nurses to better engage in and manage end-of-life caring decisions, develop better communication skills and forge stronger links between nurses and doctors.

3. Methods

Consciously subjecting to this study's philosophical foundation illuminated the researcher's methodological decision to use a Constructivist Grounded Theory (CGT) design, a qualitative research inquiry following the methods of Charmaz.

Participants in this study were purposely and theoretically selected. The inclusion criteria for those who were purposely selected included senior ICU nurses with at least ten years of critical care nursing experience, regardless of their positions/rank, as long as they have experienced participating in the decision-making and care for patients during WDVS (whether formally as part of a hospital ethics committee or informally during consultations), and who are willing to participate in the interview process. The group of participants comprised twenty ICU nurses who work in a critical care unit at a secondary and tertiary hospital in and around Bulacan and the National Capital Region. Fifteen (15) nurses were female, and five (5) males. Their years of critical care experience ranged from 10 to 30 years and were gained in various geographical locations. True to the nature of grounded theory design, the study also used theoretical samples, which included four (4) doctors in the ICU, (5) junior nurses and (10) family members of WDVS patients. The researcher espoused theoretical saturation when the researcher continued data collection for theoretical insights, but the analysis revealed nothing new, thereby recognizing repetition (Page et al., 2019).

In this study, data were collected using interviews and observational field notes. The interviews were organized as an intensive one-to-one semi-structured interview in Taglish (i.e., code-switching in the use of English and Tagalog languages). An interview protocol was utilized, which commenced with an open-ended question known as the grand tour question - "How do you carry out your caring decisions for patients withdrawn from ventilatory support?" Further questions from the interview guide were posed to clarify ICU nurses' responses or based on what was viewed during observation. In addition, the observation was undertaken in each ICU as the critical care nurse participated in the decision-making process and as the participants cared for patients during WDVS. Observational data collected through watching and listening were recorded as field notes, which enhanced theoretical sensitivity.

After completing the initial interview, part of the initial analysis involved taking a paragraph of transcript text and writing a memo that adhered to the conventions recommended by Charmaz. The researcher used memos not just as a mechanism for recording ideas but as an integral part of theory formation and revision.

From this, the coding process following Charmaz (2017) was employed, as seen in Figure 1.

4. Results

The data analysis undertaken throughout this study has resulted in forming the core category *Perspicacity*, which draws the categories ***V***oicing Out, ***E***stablishing realities, ***N***avigating transitions, ***T***aking the time, and ***S***erving a Good Death (VENTS process) together.

Theme 1: Voicing Out

Voicing Out is a concept that involves raising the thought of treatment's futility and transitioning to end-of-life care in ICU nursing. Participants in this study acknowledged that not all nurses were comfortable with this involvement and that the ultimate decision regarding the transition to palliative care lay with doctors. Strategies such as recognizing futility, giving hints, speaking up, and taking initiative (Table 1) were used to voice out the idea of "where are we going with this patient."

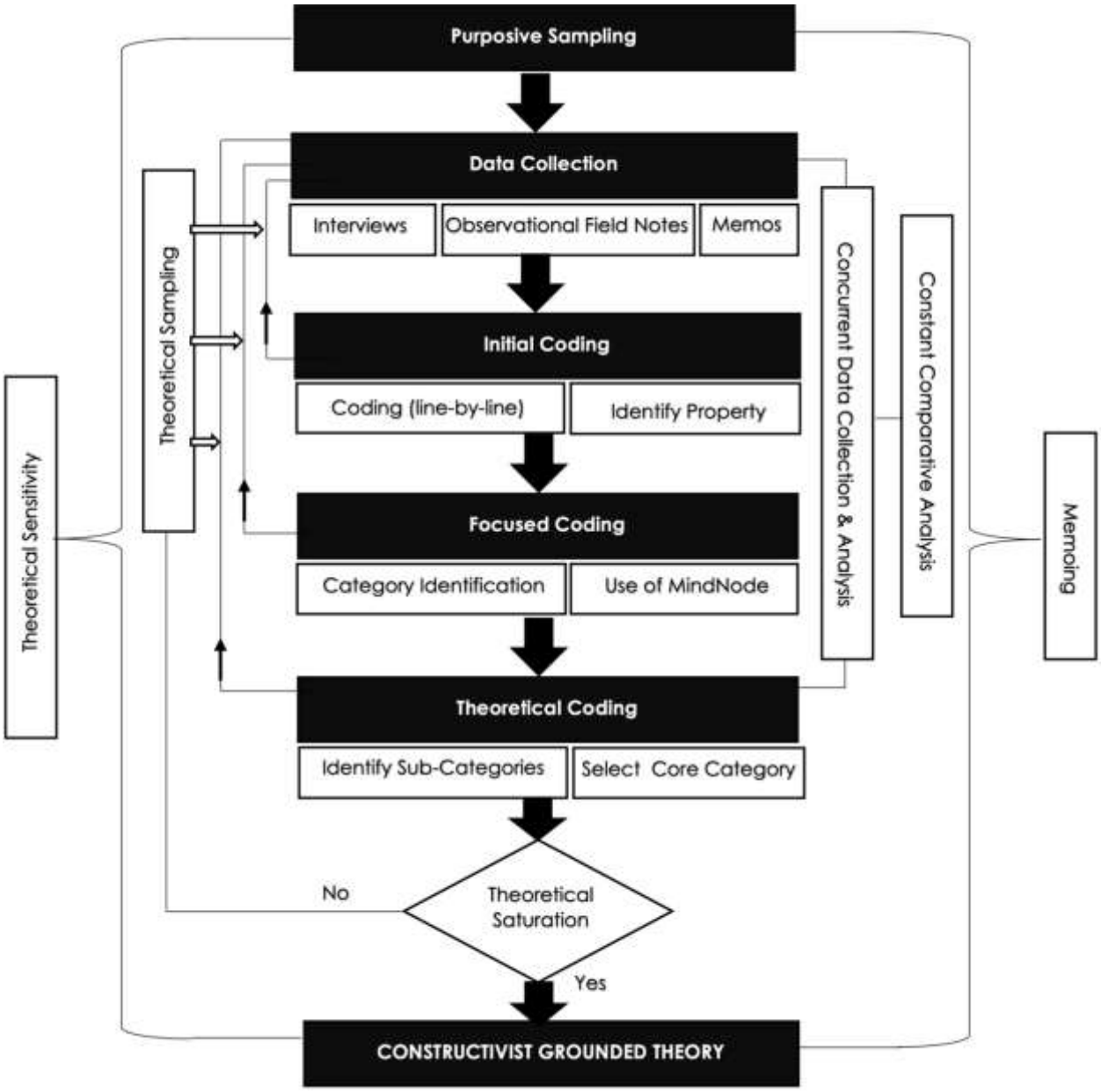

Figure 1. Data Gathering, Coding, Analysis in the Constructivist Grounded Theory Approach by Charmaz

Recognizing futility provides a strong rationale behind an ICU nurse's decision to voice out end-of-life care concepts. Nurses can start the conversation with a doctor or associate charge nurse, who can promote a discussion around the merits of moving to end-of-life care as reflected in the following:

> …sometimes they (family members) would seek for our advises; she asked me about her husband's heath status, so I said it wasn't looking good… Because at that time, she also shared that she was already financially drained, compounded with the financial burden; then she asked me if the ventilator was stopped and withdrawn, what would happen to the patient…(Nurse12)

Giving hints was a non-direct approach to voice out, referring to reporting facts about a patient's worsening condition to medical colleagues and considering stopping treatment indirectly.

> …I would report all patient information that indicates a poor response to treatment… the doctor would then start laying out the No Heroic Measures option for the family to sign the waiver, waive laboratories, waive NGT and all the treatments (including the ventilator support) … (Nurse17)

Table 1. Categories and properties under the Sub-Category Voicing Out

Sub-Category	Category	Property
Voicing Out	Recognizing futility	Not responding to treatment
		Assessing further
		Struggling patient
		Family raising concerns
	Giving hints	Factual reporting
		Signaling cues
		Using previous experience
		Having conversations with other colleagues
	Speaking up	Introducing the idea
		Seeking help from senior
		Becoming involved
		Voice enabling
	Taking initiative	Acting as conduits
		Being proxy
		Bringing the team together

It was also emphasized that the length of experience is key to be heard and trusted by the doctors as this equates to competence Nurse20, who has been in the practice for 29 years, even referred to such nurses as having a "clinical eye," which means being competently capable of recognizing the realities about a patient's condition.

> …If he (the doctor) has observed an ICU nurse to have a "clinical eye", he develops trust to this nurse that she is good in what she does, she knows how to assess a patient, probably due to experience…(Nurse20)

Theme 2: Establishing Realities

Establishing Realities is a crucial process for ICU nurses to navigate the realities of patients' conditions and their relatives' situational understanding during the dying process of a terminally ill patient. This process involves identifying information needed to formulate their opinion regarding a patient's chances of survival and determining the timing of transition to end-of-life care. The process is facilitated by their emerging Perspicacity. Value judgments and ethical principles are also part of their caring decisions. The lack of a structured critical care pathway for end-of-life situations makes it difficult for junior nurses and smoother for experienced nurses. The only source of nurses' competence is their experience in critical care.

Table 2. Categories and properties under the Sub-Category Establishing Realities

Sub-Category	Category	Property
Establishing Realities	Exploring choices	Monitoring patients
		Re-assessing data
		Making things clear
		Discussing possibilities
		Managing active treatment
		Raising financial issues
		Making reference points
	Determining patient's quality of life	Examining pre-illness patient's state
		Understanding of the family of the disease process
		Defining the influence of age
		Equating withdrawal with limiting care
	Managing family turmoil	Helping family to understand
		Active listening to family
		Facilitating family meetings
		Being present for subtle questioning
		Respecting family's decision
	Resolving uncertainty	Communicating
		Involving family in making the decision
		Securing consent

		Facing conflicting values
		Resorting to divine will
		Praying
		Managing emotions
		Acknowledging death not as a failure

The process of Establishing Realities takes place during rounds and family meetings, where a nurse is always present, and the patient's family is brought into the process. The timing of withdrawing ventilator support is unique to each patient and their situation, and maintaining the patient's comfort and dignity is a key goal. A balance between ICU nurses' desire to keep the patient at the center of care and acknowledging family members' need to come to terms with what is happening is essential.

The conditions of exploring choices, determining a patient's quality of life, managing family turmoil, and resolving uncertainty (Table 2) occur in these contexts. In these processes, nurses have to still be respectful of whatever decisions that would be made.

> … for some families, it is just quick because they see the poor condition of their patient and that they have had a good life or that they are old, while others would request a bit more because they are not ready [for the patient's death], whatever it is, you still have to respect their decisions…"(Nurse07

For Filipino nurses, this situation can be a dilemma as it philosophically contradicts the basic tenets of their faith. They need to revisit their Filipino values to avoid moral distress from a medical phenomenon known as euthanasia, which is influenced by social norms and religious values. With experience, Filipino nurses become calmer and more compassionate, overcoming initial discomfort and navigating complex ethical dilemmas. They often pray, seek guidance, and rely on divine will and spirituality. They acknowledge death as an inevitable part of life and recognize that it is not their fault as critically ill patients. The interplay of Filipino culture and spirituality is crucial in resolving uncertainties, especially in ethical decision making.

> …I would say, "Ma'am, you know that our lives are ultimately in the hands of God; we are here as instruments of support" That is what I say to them, we would give whatever your husband needs, but if you are asking if there is hope for the patient to survive, only God knows this so let us pray (for him) …(Nurse17)

Theme 3: Navigating Transition

The Navigating Transition category involves the transition from ventilatory support to end-of-life care, where ICU nurses take control. This process involves providing privacy and shifting from a cure to care approach (Table 3), which all interlink to assist in providing good end-of-life care. Nurses play a crucial role in reconnecting patients and their families, removing equipment that promotes this sense, and engaging family members in the care of their loved ones. The strict nature of ICU policies can be overwhelming for both patients' families and nurses.

> …as a nurse, you already have an idea of what decision the family would make (i.e. withdrawing the patient from life support); therefore, you would do everything to allow them to spend time longer with their loved one, even at times going against hospital policy in terms of visiting hours…" (Nurse13)

Table 3. Categories and properties under the Sub-Category Navigating Transitions

Sub-Category	Category	Property
Navigating Transitions	Providing Privacy	Closing curtains/door
		Allowing more family presence
		Transferring to Step Down ICU
		Relaxing visitation parameters
	Shifting from Cure to Care	Pre-planning with family
		Guiding junior nurses
		Communicating adequately
		Involving family with extubation
		Acknowledging nearing death
		Explaining extubation
		Turning off the machine
		Shifting to greater nursing responsibility

Nurses have implemented innovative ways to allow more family presence in the ICU, such as video calls with family members and allowing family members from outside the country to have private time with the patient.

The transition from cure to care involves the cessation of active treatment and the commencement of comfort care. Nurses face personal challenges in withdrawing treatment, such as extubation and palliative care, which may be due to a lack of experiential knowledge.

> …If the nurse on duty doesn't feel comfortable, then you step in. I was like that before…if it was decided that the patient was to be extubated and there was a relatively junior nurse in there that didn't feel comfortable doing that…" (Nurse02)

The decision to palliate a patient marked a shift in focus for the patient and greater responsibility for nurses. Some nurses even turned away cardiac or vital sign monitors during the dying process to allow family members to focus on the patient. The transition phase marked an explicit shift, acknowledging that death cannot be prevented and success now rests on the ability to serve a good death.

Theme 4: Taking the Time

The subcategory of Taking Time relates to the element of time involved in the caring decision process of ICU nurses. Time is an ever-present element throughout end-of-life processes, affecting every facet. The goal is to allow patients and their families time to prepare for the death of a loved one while also ensuring their comfort and dignity.

> "…Give the family the time, whether that takes a day, because you are actually giving them the time to come to terms with what's happening, and they could at least hold their loved one, and that makes a difference…" (Nurse05)

Table 4. Categories and properties under the Sub-Category Taking the Time

Sub-Category	Category	Property
Taking the Time	Delaying the time	Finding the balance
		Prolonging life
		Preparing the family
		Creating time
		Negotiating
		Playing catch up
	While waiting for the death time	Estimating the death time
		Making time more intimate
		Increasing physical connection
		Trying to maintain control
		Being present during withdrawal
		Attempting to ease anxiety and guilt
		Providing explanation

The transition to palliative care involves negotiations between nurses and families to prolong the patient's life and allow family members to prepare for the nearing death of a loved one. Nurses play a significant role in helping the family manage their emotions and anxiety, ensuring they are not causing unnecessary suffering.

> …we talk to them to ease the feeling of guilt, like "Ma'am, you did everything you could; we saw how you managed all his needs, how you bought his medications… sometimes, there are relatives who would say, "Yes, my son's (or my husband's) body has suffered enough…(Nurse13)

Theme 5: Serving a Good Death

The final subcategory of Serving a Good Death focuses on the caring decisions of ICU nurses in facilitating a peaceful and comfortable death for WDVS patients. Nurses play a vital role in guiding patients' families and ensuring a good death for their patients. They prioritize pain management, comfort measures, and ensuring continuity of care (Table 5). Nurses must build relationships with patients and their families, minimize interruptions, and communicate effectively. Maintaining dignity is essential, and nurses must understand when to palliate.

> …comfort really (is the most important) because prior to that, they have been experiencing a lot of pain, so we want them to, at least in their remaining hours, they would be comfortable and he/she would not feel any pain… (Nurse11)

Table 5. Categories and properties under the Category Serving a Good Death

Sub-Category	Category	Property
Serving a Good Death	Dying free of pain and anxiety	Tending comfort needs
		Managing pain
		Having family say their goodbyes
		Drawing from life experiences
	Ensuring continuity of care	Developing the skills
		Maintaining similar assignment
	Maintaining Dignity	Understanding when to palliate
		Continuing to perform basic nursing care
		Talking to patients
		Creating positive memories
		Discussing impacts of culture and spirituality
		Not allowing the patient to die alone.
	Nucleating patient's needs	Remembering patient as reason of care
		Advocating for the patient

In the Filipino context, maintaining dignity involves meeting physical, psychological, and spiritual needs, maintaining comfortable environments, having loved ones attending to their needs, openly expressing concerns, plans, and wishes, having good and healthy family relationships, and being at peace with God.

> "…I tell them (relatives) that they could hug, talk, hold their patient's hand/head…make them feel that they love the patient. I also tell them to talk to the patient because the patient could still hear them since that is the last sense that fade before death, so tell him/her everything they want to tell him/her…" (Nurse13)

The Caring Theory emphasizes the importance of guiding patients' families as an extension of nursing care, finding meaning in illness and suffering, and optimizing relationships and family care.

In Filipino culture, nurses are conscious of the comfort that many families find in religious beliefs and rituals, often asking for prayers and other religious rituals to convey the seriousness of the situation to the family.

The data analysis undertaken throughout this study has resulted in the formation of the core category *Perspicacity in Caring Decisions*. Perspicacity is the ability to quickly understand situations and make accurate judgments, especially in ICU nurses. It is shaped by clinical and life experiences, providing skills to navigate the critical care landscape. Perspicacity in caring decisions involves supporting patients and their families, reflecting on past experiences, and valuing cultural beliefs. In the Philippines, cultural and spiritual norms influence decision-making and care in end-of-life situations, with Filipino nurses often involving religious rituals and prayers to convey seriousness (Figure 2).

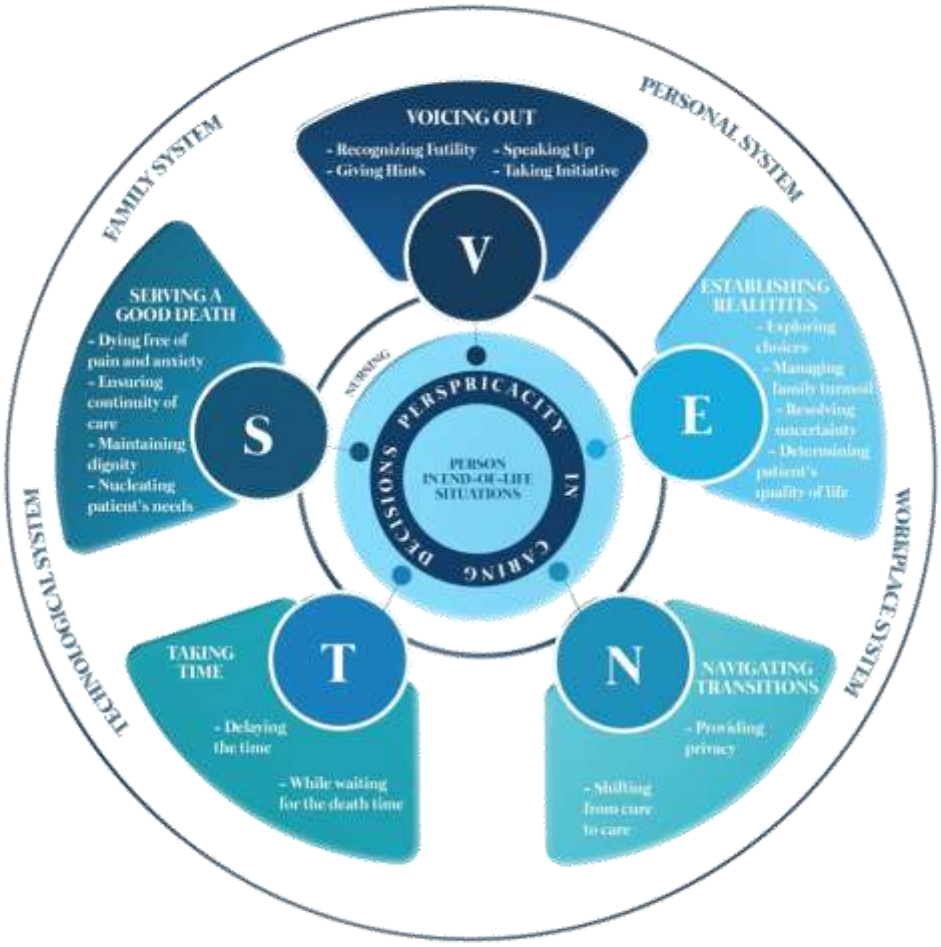

Figure 2. The VENTS process towards the Grounded Theory of PERSPICACITY in Caring Decisions

5. Discussion

The meaning and value of death confronts ICU nurses on a daily basis in hospitals across the globe. Nowhere is this more demonstrable than through decision-making and caring processes about commencing palliative care or withdrawing life-sustaining measures. Understanding withdrawal of ventilatory support as a predominantly intensive care–centric concept, Condon et al. (2014) reported that care at the end-of-life is proving to be a significant field of expertise in critical care and, therefore, requires the same commitment to competence and knowledge acquisition as all other facets of ICU practice. Coombs (2017) argued that operationalizing in this "medicalized" and "technophilic" setting, the nursing philosophy of care is seen to overlap with the decision-making process. This then constitutes the caring decisions of ICU nurses that continue up to and beyond the moment of death.

The study found that confidence and experience played a role in nurses' ability to influence situations, with senior nurses being prepared to share their opinions with doctors regarding their patients' care plans (McMillen, as cited in Rostami et al., 2017). Working relationships between doctors and nurses also influenced how a recommendation was received. Nurses held differing perspectives on how valued their input was in this context.

The research also highlighted the importance of experience and not being a nurse's decision in end-of-life caring decisions. This study found that nurses had the opportunity to voice out or be a part of the decision-making process at the end-of-life, but it was up to individual nurses to step in. The hospitals where the study took place did not have an established institutional ethics committee, and decisions were happening informally. Nurses act as conduits of information or the patient's and/or their families' proxy (Robichaux & Clark, 2016). The study emphasized the value of the experience for nurses' voices to be heard, which guides them when involved in end-of-life caring decisions.

For nurses to feel comfortable voicing out, they needed confidence in being listened to by the person they chose to discuss this with. This led to a passive light, as observation is not the only tool available to nurses. The study also highlighted the importance

of speaking up and being heard, which significantly impacts patient safety, job satisfaction, and teamwork (Kisorio & Langley, 2016; Yekefallah et al., 2019).

Some nurses reported that something within them imbued them to speak up, which they stated they learned either during nursing training or from colleagues who role-modeled this behavior. Research by Kisorio and Langley (2016) revealed that patients' and nurses' faith beliefs were important factors when making end-of-life caring decisions, highlighting the importance of communication.

The findings continue to highlight the gap between ICU nurses' input into decision-making at the end-of-life and their involvement in care processes. The domain of nursing became apparent once the phase of Establishing Realities was entered into.

The lack of a structured critical care pathway for end-of-life situations (Noome et al., 2016; Vanderspank-Wright et al., 2018) makes handling the situation difficult for junior nurses and smoother for experienced nurses. Their emerging Perspicacity assists nurses at the bedside in Establishing Realities by providing them with prior knowledge regarding what needs to be accomplished during the end-of-life caring decision process. It is essential for nurses to understand their own feelings when discussing end-of-life care (Pattison & Wiseman, 2018)and have the skills to collate the information needed to make caring decisions.

The finality of the decision to withdraw treatment can be interpreted as a simple choice between life and death. The ethical dilemma under the umbrella of non-maleficence emphasizes that any omission of a life-sustaining treatment is tantamount to euthanasia or assistance in the patient's suicide. In the Filipino context of dying during WDVS, families are weighing the use of expensive treatment and may consider comfort care instead of active treatment.

Understanding the consequences stemming from Establishing Realities and the process of exploring choices is crucial for ICU nurses to navigate the transition to end-of-life care. They must work with family members to provide explanations related to treatments, procedures, and prognostic indicators and have the time to be with families and support them (Vanderspank-Wright et al., 2018). Shared decision-making is a dynamic process that involves sharing responsibility for end-of-life care decisions between patients and their families, as well as the healthcare team. This approach aims to achieve a consensus that acknowledges the patient's beliefs and values while providing support and comfort for family members. Nurses play a crucial role in this process, as they must move away from unilateral decisions that do not consider the patient's wishes. Ong, Ting, and Chow (2018) described this act of caring for the family as 'stepping in' where nurses support families and establish rapport, creating a sense of familiarity and making end-of-life care less complex.

The ethical principle of fidelity requires healthcare providers to be faithful and truthful to the dying patient and their families. Providing ongoing information about the patient's condition is essential for the decision-making process. Nurses and doctors working in ICUs should develop expertise in working alongside families as surrogate decision-makers, fostering sound decision-making and quality palliative care.

Navigating Transition is a crucial aspect of end-of-life care, where nurses take control of the transition from curative to care-based approaches. ICU nurses are central to this part of the dying continuum, taking ownership of the transition while being mindful of potential barriers.

Providing privacy involves focusing on the patient, increasing family presence, and considering the needs of other patients in the unit. This approach is consistent with studies by Ong, Ting, and Chow (2018), who found that family presence provides an opportunity for them to reconnect with the patient. Providing privacy also involves relaxing visiting hours and visitor numbers to support families coming together (Bloomer et al., 2016). A step-down unit from the ICU caters to dying patients, creating a private space for extended periods of time. Reconnecting the patient and their family is essential to address barriers created by the technological nature of the ICU environment.

Navigating Transition also marks a shift away from curative care during WDVS to palliative care. Key interventions include withdrawing mechanical ventilation and administering pain relief. Ceasing ventilatory support and/or extubation is influenced by participants' experiences, aiming to prepare families for the changes during and after withdrawal (Toles et al., 2018).

Ceasing this life sustaining intervention was also interwoven with the category of *Taking the Time,* with nurses as advocates for patients when their dignity may have been compromised, especially if letting them die becomes prolonged due to family negotiating for more time.

Nurses in ICUs must manage time effectively, as it is a crucial aspect of end-of-life care. With life-sustaining technology and specialist knowledge, patients can be kept alive longer than at home or in another part of the hospital. Nurses aim to facilitate this

process without compromising patients' comfort and dignity (Pattison & Wiseman, 2018). Time can be objective or subjective, with objective time being actively beginning the withdrawal process and the moment of death, while subjective time includes watching and waiting, being with patients and families, and nurses' experiences of reflecting on the process.

In managing end-of-life caring decisions in the ICU, nurses coordinate navigating to transition, establishing realities, making the judgment to voice out, and pulling these elements together to serve a good death. The study highlights the importance of time in nurses' influence on end-of-life processes and how their emerging Perspicacity helps harmonize these processes. Delaying time and waiting for death time are two key aspects of this process (Rostami et al., 2017). Nurses must build trust with families, understand their cultural needs, negotiate the withdrawal of treatments, and provide support to the family. Waiting for death time is another condition that correlates with providing a good death. Experience in caring for the dying deepens nurses' understanding of how to engage with patients and their families during this final journey.

Serving a Good Death focuses on the caring decisions of ICU nurses in facilitating a peaceful and comfortable death for patients. Common elements of a good death include dying free of pain, ensuring continuity of care, nucleating patient needs, and maintaining dignity. A good death also allows people to determine who is present to have time to say goodbye, to control the timing of death, and not to have continued medical interventions when the quality of life is low and there is little or no hope of improvement (Ashby, 2016).

Dying free of pain and anxiety is seen as an important condition of a peaceful and comfortable death, and nurses are the advocates who are in a position to ensure the pain management plan is comprehensive and achievable. This significantly helps in reducing patient suffering in the dying continuum.

Maintaining dignity and not being alone are important elements of a good death. Family and nurse presence at the bedside is considered paramount, and it is considered both inappropriate and inhumane to allow patients to die alone (Vanderspank-Wright et al., 2018). This is facilitated in the work environment by creating a private space where additional family and friends can remain present for more sustained periods of time.

In the Filipino context, family plays an unusually significant and central role in the lives of its members (Ho et al., 2023). Nurses can guide patients' families as an extension of nursing care, finding meaning in illness and suffering. They are influential agents in the building and maintenance of functional relationships and family cohesion (Laurente, 2011).

Family meetings are held regularly to assist in achieving this, allowing for updates regarding the patient's status, questions from family members, and decisions regarding whether to continue treatment. Working with families encompasses several themes, including information sharing and contextualizing the complex aspects of intensive care (Hold, 2016; Watsons, 2018).

Dying is fighting a battle that cannot be won, and potentially suffering is the hallmark of a bad death (Wilson & Hewitt, 2018). Filipino cultural and spiritual norms also influence maintaining dignity. Nurses should explore whether the patient would value a visit from a clergy person and the importance of religious rituals (Karnik & Kanekar, 2016) to help the family accept their loved one's death. A nurse's ability to explain the dying process and provide guidance to family members is crucial in caring for the dying. Effective communication is essential in determining a good death trajectory, and poor decision-making and communication can result in life-prolonging interventions that were not wanted (Dobson, 2017).

The competency and skill of nurses caring for their relatives are cited as the aspect of admission they are most satisfied with. As De Vries & Plaskota (2017) observed, within the ICU setting, advances in both knowledge and technological capability have not only improved our capacity to restore health but to provide patients with a pain free and dignified death. Most participants concentrated on looking beyond a cure to see that death is not a failure but the end of one journey and the beginning of another (Karbasi et al., 2018). A stronger degree of empathy is achieved through sharing the lived experience of others at some stage. The inability to see dying as a failure is tantamount to a compromised ability to reduce suffering, hear the patients' voice and improve quality of life at the end of life.

This aligns with hospice and palliative care movements, which emphasize the importance of acknowledging death as an outcome in providing a good death. A dignified, comfortable death is consistent with Wilson & Hewitt's (2018) study, which states that a good death is having the chance to be prepared for death, say goodbye to loved ones, and be free from pain and suffering.

In serving a good death, a shift in thinking took place when nurses stopped seeing death as a failure but rather as an opportunity to see success as something other than striving for a cure.

6. Conclusion

A situation-specific practice nursing theory of *"Perspicacity in Caring Decisions"* was formulated using the constructivist grounded theory method. It is classified as such since its concepts and principles apply only to a narrowed scope and focus on patients during end-of-life situations. This theory stands on a strong foundation built from five interlinked VENTS sub-categories. *Perspicacity in Caring Decisions* brings together and contextualizes what was happening throughout the processes of end-of-life caring decisions of ICU nurses. Moreover, the theory reflects and guides how nurses carry out their caring decisions for patients in end-of-life situations.

This study highlights the importance ICU nurses bestow on relationships and dialogue in end-of-life caring decisions for patients withdrawn from ventilatory support. This study has also reinforced how ICU nurses' constant bedside presence make them a key asset throughout the end-of-life continuum. It was highlighted that through their "Perspicacity" that was gained through critical care experience with a deeper understanding of end-of-life situations, ICU nurses are able to overcome barriers to speaking up, maintaining dignity and being instrumental in facilitating a good death. While ICUs are not traditionally seen as optimal environments in which to die, this study has found that as long as nurses have their "Perspicacity," they are equipped to manage this challenge. Specifically, the theory of "Perspicacity in Caring Decisions" suggests how patients and families may be facilitated to have experience a good death in a technologically focused environment and accepting death not as a failure but as a milestone. Despite the challenges of working in an environment that is focused on treatment and cure, the theory suggests that nurses stay focused on the needs and suffering of patients and families.

The theory also involves an interplay of concepts involving caring and ethical decision making. In addition, end-of-life caring decisions are interlinked with ethical principles. So, as nurses carry out their caring decisions, the gained perspicacity guides them in situations that are ethical in nature. This includes principles such as patient autonomy, beneficence, non-maleficence, justice, and fidelity.

6.1 Study Limitations and Future Research

The study poses cultural limitations and applications. The focus on the Filipino context may restrict the applicability of the developed constructivist grounded theory to other cultural settings.

Future research should aim to replicate this study with more diverse samples to validate the Perspicacity of Caring Decisions theory across different populations and healthcare settings. Furthermore, exploring how contextual factors such as organizational culture and healthcare policies influence ICU nurses' caring decisions could provide valuable insights for improving end-of-life care practices globally. Additionally, longitudinal studies could investigate the long-term effects of implementing strategies informed by the developed theory on patient outcomes and family satisfaction in end-of-life care.

The entire VENTS process generates new areas of research interest that could be explored built on the findings of this study. For example, barriers to participating in decision-making regarding withdrawal of ventilator support need to be investigated in greater depth in order to facilitate and clearly explicate what this aspect of the nursing role should be. A critical evaluation of existing ventilator or other treatment withdrawal protocols and clinical practice guidelines, as well as how these guidelines are actualized in intensive care, would help to identify and solidify best-practices. Considering the qualitative limitation of this study, nursing advocates dealing with similar subject matter are enjoined to replicate this study in a wider-base population and in a quantitative study to develop tools or instruments comprising measurable constructs pertaining to the caring decisions of ICU nurses.

Funding: This research received no external funding.
Conflicts of Interest: The authors declare no conflict of interest.
Acknowledgments: The successful completion of this paper was made possible through the substantial contribution of my co-author. I know that my words are not even enough to express my gratitude. Dr. Teodora M. Delos Reyes was responsible for the recruitment and significantly contributed to the conceptualization and analytic phase.
Ethical approval: Ethical approval was granted by the Institutional Ethics Review Board of each hospital where the participants were recruited.
Informed consent: Participants in this study provided written informed consent to voluntarily participate in the research, demonstrating their understanding of the study's purpose, procedures, and potential risks involved
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