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From vulnerability to passion in the end-of-life care: The lived experience of nurses

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ABSTRACT

Purpose: End-of-life (EOL) care is considered to be inherently difficult and vulnerable for patients and nurses. It also seems hard to develop passion for care during these problematic times. This study elucidates how EOL nurses interpret their care experience and how they transform their experience and mindset.

Methods: This study was conducted by organizing a reflective group based on the concept of group analysis for oncology and hospice nurses to share their experience. Thirteen registered nurses were enrolled from a medical center in northern Taiwan. Data drawn from the group dialogue was derived from six digitally recorded sessions and then analysed alone with the researcher's diaries and participants' feedback sheets. Interpretative Phenomenological Analysis (IPA) was used to analyze the data.

Results: The results showed that nurses who provide EOL care actually experience suffering by witnessing patients' suffering. However, the suffering authentically drives the nurses to encounter their own inner selves, to induce the shift of mindset, and then allow them to continuously provide and maintain the passion in EOL care.

Conclusions: This study provides a new viewpoint for understanding of EOL nurses' experiences, indicating that this line of work may be recognized as a privilege. We recommend that the setting of a nurse reflective group is important and it may be considered in providing EOL care training for nurses. Hopefully the study results could shed lights for future policies regarding EOL care.

1. Introduction

It is difficult to be a nurse in times of nursing shortages and modernization of the medical workplace. In the 21st century, modernization and advanced technology represent the mainstream contemporary form of medicine and have generated unique features in the clinic (Armstrong, 1987; Nairn, 2015). When the focus of modern medicine is on saving or prolonging life rather than caring the personal demands of patients, appropriate care and humanity may be ignored. The aforementioned situation raises profound challenges in nursing, especially in end-of-life (EOL) care, although the hospice movement has developed from a reaction against this longstanding trend (Brummen and Griffiths, 2013). Consequently, conflict can arise between the nursing paradigm and humane care, and complex ethical and moral dilemmas may emerge (Goh, 2012; Johnson and Gray, 2013). Meanwhile, critical global issues surround work-related traumas, such as compassion fatigue within nursing practice, particularly in certain areas such as the intensive care unit (ICU), the emergency room (ER), oncology wards and hospice units (Ablett and Jones, 2007; Mealer and Jones, 2013). Nurses who provide EOL care are recognized as high-risk professionals in terms of compassion fatigue (Corso, 2012) due to the demands of this type of care (Wilson, 2014), which means that these nurses can easily become distressed and run-down in the workplace. Therefore, it may seem difficult to maintain passion for care during these problematic times, but passion is essential for nurses to stay within the profession.

EOL care is considered inherently difficult for both patients and nurses. Nurses who work within the field are frequently exposed to various levels of negative experiences, such as emotional pain, overload or work-related stress (Ablett and Jones, 2007; Boroujeni

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et al., 2008; Johnson and Gray, 2013). For nurses themselves, the most difficult part of these experiences is not only the physical labour but also the emotional and spiritual labour that includes anxiety, powerlessness, uncertainty, distress, grief, and frustration (Browall et al., 2014; Luxardo et al., 2014; Wilson, 2014). Suffering also comes from witnessing patients suffer. Performing cardiopulmonary resuscitation (CPR) is an example of direct patient care and is said to be a traumatic experience; some nurses have described this intervention as torturous (Mealer and Jones, 2013). Indirect exposure, such as the observation of patients suffering or inevitable death, can also add to the emotional pain of a nurse (Browall et al., 2014; ealer & Jones, 2013).

Traditional nursing education trains nurses to care patients with compassion, altruism and competence. However, such training fails to teach nurses how to live within the modern practice environment that emphasizes economics, efficiency and task-orientation (Ruth-Sahd, 2014). Moreover, nurses are assumed to have the ability to take care of themselves including manage the conflicts and the emotions generated in such environments (Dahlke and Stahlke Wall, 2016; Newham, 2016). Most nurses do not leave themselves enough time to reflect on what happens after a patient's death. Because they do not have time to deal with these circumstances, the nurses also feel that their managers do not appreciate the stress caused by EOL care (Wilson, 2014). Additionally, traditional Chinese culture does not encourage nurses to discuss issues associated with death; instead, nurses are expected to give hope to EOL patients (Dong et al., 2016). Therefore, nurses who provide EOL care could be viewed as vulnerable or as “the caretakers of suffering” (Luxardo et al., 2014). Nurses need to be supported adequately by regular staff meetings and continuous education (Wilson, 2014; LeBaron et al., 2017).

However, previous studies have verified suffering as an opportunity for nurses to transform or modify their personal and professional selves, which allows nurses to embrace their suffering and to value it rather than dismiss it (Huang et al., 2016). As indicated by Browall et al. (2014), nurses view the experience of EOL care as a privilege, giving them new insight into their own lives. Nonetheless, for some nurses, dismissing the experience is the only option (Hanson and Taylor, 2000).

Currently, most research efforts have concentrated on EOL patients' needs, feelings and the quality of care. Instead, less attention has been paid on EOL nurses' feelings and how they maintain passion while providing EOL care. Thus, the goal of this study was to explore nurses' lived experiences in the provision of EOL care.

2. Methods

This study used Interpretative Phenomenological Analysis (IPA), which is an inductive approach to qualitative, experiential research (Smith et al., 2009). Our study examined how EOL care nurses make sense of their major lived experiences by exploring nurses' relatedness to, or involvement in, a particular event or process (phenomenon). Based on IPA perspectives, participants can set their own agenda and talk about their own priorities in their own terms. This study included a reflective group based on the concept of group analysis. Group analysis is a psychotherapeutic technique that is theoretically founded in psychoanalysis (Pines, 1996). The reflective group in this study was unstructured and unrestricted, focusing on the here and now, with the only set question being like “Does anyone want to share something today?” The researcher acted as the facilitator for the group interaction, but did not impose on the group dialogue (Buber, 1988; Foulkes, 1991). Therefore, the participants could speak freely with reflectivity. In our six group dialogues, although the topics and interview guidelines were not previously established, the participants usually shared their working experiences and their lived experiences. Some issues emerged repeatedly in different sessions. The relationships between the six sessions are interwoven and interconnected.

2.1. Participants

An intentional sampling of 13 female nurses was conducted at a 1800-bed military hospital in northern Taiwan. Including the main campus, the hospital consists of four branches which are distributed in different locations. Participants were invited by flyers that the researcher brought to wards related to EOL care. At the meeting with the nursing staff, the researcher explained the purpose of this study and how the study would be conducted. Nurses who were interested could contact the researcher to sign written consent forms. All participants were trained nurses, and the majority of their nursing experiences included providing direct nursing care to EOL patients. However, most of them had not received formal training related to palliative or hospice care. The nurses had provided care in settings such as cancer, hospice, and paediatric oncology wards. The average age of the participants was 38.4 years, with an average number of working years of 12.6. Regarding education, six of the participants held bachelor's degrees, five held master's degrees, and two had degrees associated with a nursing college. Only 3 participants were married. Five participants joined all six sessions, and the others joined at least 3 sessions. The average number of sessions joined was 4.5.

2.2. Ethical consideration

The study was conducted in accordance with the Helsinki Declaration and was approved by the Institutional Review Board on human subjects for the National Taiwan University Hospital (201208HS014). Permission to conduct the study was obtained from the head of the medical center where the study took place. All participants were fully informed about how to protect confidentiality and the anonymity of the data. Additionally, the participants were free to withdraw at any time. In addition, personal counselling was provided to the participants when they needed psychological support during and after the six sessions for six months.

2.3. Data collection and analysis

The first author served as the conductor, facilitated the group dialogue sessions every week for a total of six sessions. The length of each session ranged from 90 to 120 min. The group dialogue was recorded digitally and transcribed, and the data from the six sessions were analysed, including the researcher's diaries and the participants' feedback sheets. The transcript was analysed using thematic analysis techniques from the IPA. The primary concern of the IPA is the lived experiences of the participants and the meaning that the participants took from them. The end result is always an account of how the researcher thinks a participant is feeling, which is a double hermeneutic process (Smith et al., 2009). The analysis process was conducted as follows. First, the researcher listened to the audiotape of each group dialogue and created transcripts. Each transcript was read line by line several times, and key descriptive, linguistic and conceptual comments were noted on each transcript. The task of this level was the management of data changes to identify emergent themes as the researcher simultaneously attempted to reduce the volume of details to map the interrelationships, connections and patterns between the initial notes. The preliminary themes were abstracted and clustered into groups of themes according to common features in terms of meaning. After analysing the first transcript, the researcher reanalysed the themes as part of the dialogue context to verify whether

the meanings were accurate for the participants. Then, the researchers moved to the next transcript and repeated the analytic steps until all transcripts were completed. Lastly, the researcher looked for patterns across the cases that could represent any meaning of all the texts (Smith et al., 2009).

The rigor of this study was based on Lincoln and Guba (1985) four criteria: credibility, dependability conformability and transferability. Alongside Morse's viewpoints, evaluating the quality of qualitative research is complementary and intertwined (Morse, 2015). The strategies applied in this study included the following. (1) We aimed to support credibility and conformability and maintain the researchers' neutral stance using reflective diaries and meetings for peer review. (2) To obtain a thick and rich data set for conformability, 13 participants with valuable experience in EOL care were recruited. (3) The researchers had received group therapy training courses and had quality experience in qualitative research and data analysis. Meanwhile, the researchers made considerable efforts toward participation and prolonged engagement in the whole process of the study, including the data collection and analysis, to acquire the most essential and rich information. (4) Moreover, coding systems were used during the analysis process to improve dependability (Cope, 2014; Morse, 2015).

The exemplars in the findings are labelled with six-character codes. For example, in the code G3P7NB, "G3" indicates the third group session, "P7" means the evidence was taken from page 7 of the third session, and "NB" indicates that the evidence was produced by nurse B.

3. Results

The views that the nurses shared relative to their experiences of providing EOL care were numerous. These were thoroughly explored to determine the relationships between their experiences and themselves. Three major themes emerged, and each major theme included three subthemes (Table 1). The results showed that nurses who provide EOL care experience suffering by witnessing patients' suffering, whereas this suffering allows the nurses to authentically encounter their inner selves, consequently enables the transformation of mind-sets and further motivate them to afford and maintain passion in EOL care.

Table 1
The experiences of nurses who provide EOL care.

Themes	Subthemes
Suffering with	1. Witnessing a patient experiencing a painful death
	2. The inability to answer questions about death
	3. Disenfranchised grief
Being authentic	1. Detecting personal hidden agendas
	2. Separation anxiety from a dying patient
	3. Remembering the dead
Self-illuminating	1. Preparing for their own death
	2. Self-writing
	3. Giving and taking

3.1. Suffering with

Saving or prolonging life is the purpose of modern medicine, including for patients at the EOL stage. It is very difficult for nurses to witness EOL patients receiving advanced medicines and participate in the care process, but they can do very little for the inevitable suffering.

3.1.1. Witnessing a patient experiencing a painful death

Hospice and palliative care have been practiced for many years. However, EOL patients are still treated with advanced medicine during their final moments. Nurses experience emotional suffering when they witness EOL patients suffer under advanced interventions. Nurse E said: "My patient, at 90 years old, was sent to the hospital again because of air hunger; he was very weak. Actually, he was dying. However, at the very last moment, a family member regretted agreeing with the 'Do not resuscitate (DNR)' decision even though the patient had already signed the DNR form in advance. Then, the patient was intubated and given resuscitation. I felt really sad. I could not understand why his life needed to be prolonged? I watched more tubes being put into his body … I could do nothing but felt so sorry for him!" (G2P7NE).

Even hospice or palliative medicine can be medicalized in the modern medical field. One feature of modern medicine is the use of standard operation procedures (SOP). However, strictly following SOP but ignoring the patient as the focus in preparations for death could distract the nurses' attention from the patient and raise ethical and moral difficulties. A hospice nurse shared, "In the hospice ward, a medical team followed the hospice care guidelines to help a patient and family members preparing for death. With all steps completed according to guidelines, the patient did not die immediately. It seemed like everyone was waiting for death to come. And what was the consequence? My patient closed his eyes for the entire day and refused to talk. He isolated himself from the world. Did we force him to accept his death? I wonder. If we do not ask patients what hospice care means to them, then it would be like that we force them to wait for death and do leave them alone" (G3P5ND).

3.1.2. The inability to answer questions about death

Death is a taboo in Taiwanese culture. Nurses fear to talk about death in front of dying patients and their families, especially when the patients or families do not anticipate the coming death. Nurse H said, "Almost every day my patient asked me, 'Can you tell me if I am going to die?' I really did not know how to answer when I looked at the eager eyes and faces of the patient and family members. It was so hard for me to deal with this situation" (G2P10NH). Nurse C also shared the following: "As a nurse, I cannot tell a patient, 'Do not worry, you will be fine!' Although I know patients need some hopes, but I can't give them false one. It makes me feel bad!" (G2P17NC).

3.1.3. Disenfranchised grief

In modern medicine, efficiency and saving time are necessary. Consequently, death becomes an object of medicalization. Nurses do not have time to handle their inner feelings or they have been trained to hide their emotions, even when they encounter death. These situations result in disenfranchised grief in the workplace.

Nurse D said, "When you are on duty, you are used to suppressing your real feelings because of the crucial clinical field. You are trained as a professional nurse and supposed not to show your real feelings, which you actually have no time to handle. However, the feelings do not go away but accumulate as time goes by …" (G5P5ND).

Nurse A said, "When our patients die, we do not have enough time to deal with our emotions, and this is a kind of injury to us" (G1P9NA). These emotions influence nurses' inner selves and outer behaviours. Nurse K mentioned, "Actually, we were not aware that certain things like our behaviours had changed. The emotional suffering influenced us gradually but deeply, although we thought, 'I am OK', in our minds. But, you know, we are not OK at all" (G5P8NK).

Emotional suffering makes nurses vulnerable. Nurse C said, "Sadness is always with me, suppressed but accumulated, until I burn out. I remember a day I cried for a long time, I could not stop

crying. It is like you have a bleeding wound and you cover it with gauze, but you cannot stop the bleeding. In the end, you will collapse" (G1P11NC).

The grieving atmosphere was perceived not only by nurses but also by the entire medical team. Nurse G shared, "There were some nurses quit their jobs recently in our hospital, and 5 or 6 nurses left the ward almost at the same time. It was like a domino effect. I think entire team was impacted by this kind of sadness" (G2P5NG).

3.2. Being authentic

Providing EOL care always involves the issue of life and death, which represents an opportunity for nurses to encounter their inner selves. These encounters include the detection of hidden personal agendas, separation anxiety from a dying patient, and remembering the dead.

3.2.1. Detecting hidden personal agendas

EOL care can arouse a nurse's deep feelings associated with deceased family members. Nurse B recalled a painful experience that she could not forgive herself because she signed a rescue permit for her father who was in the EOL stage. She said, "I do not know whether my father would blame on me because I signed the permit to have him intubated for saving life." She continued, "Ten years ago, my father was sent to the ER with consciousness lost in a car accident. My mom was too shocked to do anything at that time. Then, I was asked to sign the CPR permit. But I was just a nursing student at that time. I was so frightened when I signed it. Three days later, my father still died. Since then, whenever I watch my EOL patients being intubated, I can't help feeling guilty for I have done for my father and uncertain whether my father would be angry with me. He had passed away for more than 10 years, but I cannot let the pain go. I never tell anyone, although it is still a pain in my heart" (G2P20NB).

3.2.2. Separation anxiety from a dying patient

Before reaching the EOL stage, patients may undergo long periods of hospitalization. Therefore, patients and their families become acquainted with nurses. This long care process engenders strong relationships, which make nurses feel that patients and their family members are part of their families. However, when patients are dying, nurses experience separation anxiety because the situation is difficult to accept.

Nurse B said, "My patient is 11 years old now. When he was 4 years old, he started routine treatments for his cancer at our ward. However, the cancer is so aggressive. Now, medicine can do nothing for him, which means that he is going to die. We have known each other for so long, and I am afraid of his impending death. For me, he is like my younger brother. I am not sure whether I am ready to accept his death. I should handle my feelings, but I worry to lose control and I will cry" (G3P4NB).

3.2.3. Remembering the dead

Remembering deceased patients seems to provide deeper meaning to EOL care among nurses.

Nurse A said, "Twenty-five years ago, sufficient medical resources were not available in southern Taiwan. Many patients came northbound to Taipei from southern cities. Once upon a time, my son and I travelled from northern to southern Taiwan. When we drove through a couple of cities which were my deceased patients' hometowns, I started to tell my son about the stories of those patients. Unexpectedly my son replied, 'Mom, you've told me these stories when I was little.' Those cities always reminded me of my patients and their stories. The relationships between my patients and me are like wires that connect me to them" (G3P3NA).

In addition, these connections cause nurses to use their own methods to commemorate patients. Nurse A mentioned, "My house is close to the funeral home, where I drive by every day. Sometimes, I do self-talk when I drive by the funeral home, 'How are you, 0623 and 1457?' Do you know what the number 0623 or 1457 means? When my patients died, these were the numbers assigned and labelled for them upon sending to the funeral home" (G3P14NA). Nurse A continued, "Sometimes, I shout out to those invisible patients who have died, 'I am suffering so much'. When I do this, usually I am caring for some patients who are going to die but I am not ready to take it yet. The more you have affection for or connections with a patient, the more difficult it is for you to accept the patient's death" (G3P14NA).

3.3. Self-illuminating

EOL care nurses suffer with patients and encounter their true selves. Some nurses will quit their jobs, but some nurses will decide to stay in this profession. In our study, we found that nurses who decided to stay in EOL care had formed new attitudes or states of mind consisting of courage, calmness and passion. For instance, nurses prepare for their own deaths, write reflective letters to themselves and their family members, and have gratitude for their EOL experiences.

3.3.1. Preparing for their own deaths

For nurses, overcome the taboo of death means reflecting on death in their own lives, such as attending patients' funerals in order to prepare for their own ones in advance. In group session 1, Nurse A shared, "Three years ago, I started to plan for my own funeral. I prefer to wear my nurse uniform when I die. A nurse uniforms manufacturer recommended me to wear one made in cotton instead of nylon, because the nylon uniform will stick to my bones when my body is cremated. I also want my diaries recording the stories of my patients to go with me when I am to be cremated. I did not have the courage to initiate this process previously, but this job helped me become more confident to face death. I have more passion for this job" (G1P10NA).

3.3.2. Self-writing

Caring for EOL patients also inspires nurses to do something that reflects on their lives, such as self-writing, in which the nurses write letters to themselves or their family members.

Nurse A said, "Actually, I wrote each letter to my family members with tears. I also wrote to my deceased relatives, such as my mother-in-law. In the beginning, I did not know that doing this could help me accept death" (G3P13NA).

3.3.3. Giving and taking

Although providing EOL care in modern medicine is challenging, nurses can be inspired by these experiences. Nurses realize that they can develop skills to fit in but not get away from their unique work field. Progressively, they are able to wait, forego their desires, and have gratitude upon providing EOL care. Nurse B said, "EOL care does not require us to do anything special, we just need to be there. Even though we want to help our patients, sometimes we just couldn't get involved. Sometimes, we only need to wait for a chance" (G3P8NB).

Nurse A echoed similar sentiments, "By the way, EOL care requires us to wait patiently for a chance and seize the moment" (G3P9NA). Nurse E also replied, "Although providing EOL care is not easy, interestingly I realize that doing nothing is actually doing something. We do not need to force ourselves to do something, but we must wait" (G3p10NE).

In group session 1, Nurse E mentioned that patients always die

on her shift; therefore, her colleagues have given her the nickname "White-Der Princess" (White-Der is the name of the morgue hall in the hospital). Typically, people think that the morgue is associated with bad luck. However, Nurse E had a different mind-set. She said, "I was called the White-Der Princess, but I do not feel offended. I believe that because patients trust in me, they choose my shifts to die. It is a great merit and virtue [from a Buddhism concept]" (G1P17NE).

Nurse A shared some photos of her patients and herself. She pointed to a girl in a picture and recalled, "This teenage girl was diagnosed with mandible cancer with metastasis, but she did not accept surgery or chemotherapy because she wanted her face to hold as a whole piece. Her mom let the girl receive alternative medicine. When she returned to our hospital, she was in a poor condition and had entered the terminal stage. Her mother called me in a late night asking me if I could stay with her daughter in her last moments. I felt so sad when I saw her; her wound had festered so badly. I knew that she was afraid of death, but I was also terrified because this was the first time I had stayed with a dying person. The only thing I did was to tell her, 'Don't be afraid, I am here.' I remember I was in tears, but I stayed with her until her last breath. After she died, I felt so peaceful and was not afraid at that moment" (G3P9NA).

On the other hand, nurses realize that the benefits of EOL care are mutual. As you give, you also gain. "We were so lucky to have the opportunities to encounter those patients. By providing care, we were required to confront and prepare for death and cherish our lives. I think this is a privilege for a nurse. Death is not a terrible thing anymore. It is positive energy that directs us. We are the ones who gain the most" (G5P4NE).

Nurse E said in the sixth group session, "EOL care teaches us to live in the moment and not to waste life. Respecting death helps us to give better care and allows us to grow from that experience" (G6P21NE).

4. Discussion

4.1. Vulnerability in caring

In all EOL situations, physicians or the families of EOL patients usually seek to preserve "life" as long as possible, even for a few days or weeks, regardless of the means and the pain involved to do so (Kaufman, 2005). In our study, all nurses had witnessed or participated in EOL patients' suffering due to aggressive interventions that did not benefit the dying patients but instead made the patients exhausted and deprived them of a peaceful death. Additionally, they shared that when their patients suffered, they felt emotional distress themselves, such as frustration, anger and pain. This phenomenon shows that nurses suffer because of the suffering of their patients, which is what Buber (2006) called "inclusion". This concept of "inclusion" is different from "empathy", which is normatively discussed. Empathy is not realistic enough. Empathy is an attempt to project oneself onto another and experience an event as if one is the other, but it tends to blur the independent positions of the two human beings. However, inclusion is the ability to experience a relational event from the standpoint of oneself and another at the same time. That means nurses, to some extent, simultaneously experience the patient's suffering both from their own standpoint and from that of the patient. In the care relationship, inclusion can also be called "suffering with" (Buber, 2006; Kakkattuthadathil, 2001; Scott et al., 2009), and this phenomenon of "suffering with' makes nurses vulnerable.

Certain studies show that EOL-stage patients hope to maintain control over their life values and independence even in their last moments (Bakanic et al., 2016). In our study, nurses emphasized that when they provided EOL care, they felt that they were controlling patients by following SOPs, without truly caring for the patients. Consequently, they gave patients hospice or palliative care according to guidelines. But the patients' reactions showed that they could not truly acknowledge their coming deaths and instead isolate themselves from the world. The deepest concerns of patients are not being "heard" and that such concerns are of little interest to caregivers (Toombs, 1998). As indicated by You et al. (2014), a gap exists between the preferences of seriously ill patients and the goals of care driven by guideline recommendations. If health care teams only follow the SOP or routine-oriented care without focusing on patients individually, this will become the norm, and hospice or EOL care can be easily medicalized and taken for granted. In this context, nurses suffer from routine frustration when observing EOL patients isolate themselves, waiting for death alone. Nurses are also at risk of feeling excluded as people themselves (James et al., 2010).

Modern medicine intends to be both efficient and economically beneficial, paying little attention to what is at stake for health care professionals. In such a work atmosphere, nurses feel pressured to make a bed available right away for the next patient after the former one has died. In addition, the nurses' needs are not acknowledged by their managers, so they experience a lack of support at the organizational level (Wilson, 2014; LeBaron et al., 2017). In our study, most nurses didn't receive the training of palliative care; they also expressed the same issue. This phenomenon is a risk factor in the development of compassion fatigue and makes nurses vulnerable. Nurses' emotions have never truly been appreciated or have been quickly invalidated as "imaginary", and the true origins of nurses' wounds are never fully acknowledged. Nurses will attempt to avoid these feelings or other related emotions. However, such avoidance by taking an "easy escape route" neither relieves EOL nurses from the feelings of concern or pain for another's suffering, nor helps themselves by allocating the work to another because it is difficult to avoid feeling compassion (Newham, 2016).

4.2. Working on the wounded

"Suffering with", or "inclusion", is also a probe to detect nurses' past experiences with their family members who have died. As Huang et al. (2016) indicated, nurses who provide EOL care may evoke personal memories of their deceased family members and experience emotional suffering. One nurse in our study shared painful memories associated with her father's death. Could providing EOL care represent a secondary trauma or a chance for healing? She did not know. In the reflective group dialogues, she presented her true feelings and reflected on her experience in the group. Although she never knew whether her father would forgive her, she needed to forgive herself first. She shared that she gained a new understanding of the experience from the meaningful group dialogues. She began to free herself from the pain, and realized that no one other than herself could heal the emotional wound. In other words, only she who knows the truth of her suffering can try to heal the wound. Being authentic is an important way to define oneself (Meyers, 2000); for nurses, this also becomes the prime focus of nursing care. This finding is consistent with the theory of Emmanuel Levinas, who proposed that if suffering has a meaning, then it is not meaningful for the sufferer, but rather the person who witnesses the suffering. The only meaning that suffering can acquire is as "suffering for the suffering […] of someone else" (Levinas, 1988).

Witnessing suffering is a part of daily EOL care work. Some research studies have found that suffering offers a chance for nurses to transform or modify their personal and professional selves. This viewpoint allows nurses to be proud of their

experiences and better themselves rather than be disheartened (Hanson and Taylor, 2000; Huang et al., 2016). Recognizing the finitude of life encourages nurse to honour life and helps them set priorities and live in the moment (Luxardo et al., 2014). Furthermore, nurses can serve as powerful tools of healing when they create openness within themselves and a willingness to look inward. From the theory of "the nurse as a wounded healer", healing power flows from the awareness of attention to one's own pain and fear. The individuals have the capacity to heal wound by transforming and sublimating the experience, allowing for the ability to therapeutically help others. Sublimation embodies emotional growth and the ability to discover meaning in one's suffering (Conti-O'Hare, 2002). Within this context, a nurse's suffering does not involve identifying with pain, but rather cultivates the ability to view it as part of human growth and development (Janssen and MacLeod, 2012). Many competent nurses have a sense of their own brokenness and connectedness to others, allowing them to be both healers and companions to the sick and dying (Corso, 2012). Browall et al. (2014) noted that EOL care provides insight for nurses into their own lives and is viewed as a privilege. Clearly, the nurses in our study did not regard their experiences as burdens; instead, they were willing to be vulnerable and acknowledged these experiences as genuine grief and suffering.

4.3. For oneself from "for the other"

Providing EOL care impacts nurses' lives in multiple ways and on various levels (Luxardo et al., 2014). One of the dimensions involves encountering one's own inner world to enable the self-understanding and self-realization that has been solidified in the ideas of authenticity and self-governance. The authentic self will prompt different ways of living (Meyers, 2000). Shown in our study, nurses realized what they really wanted, from attending a patient's funeral to preparing for their own ones. Additionally, they started to write letters to themselves and to deceased family members because writing is inherently reflexive. These actions, driven by the nurses themselves, also serve as a way to console and surmount suffering. When nurses are open and submit to suffering, they begin to develop different beliefs and behaviours in their own lives and allow healing energy to flow more freely (Conti-O'Hare, 2002). In Chinese Tao's thinking, philosopher Zhuangzi proposed the term "sitting oblivion" (Zuo Wang; 坐忘), which refers to a state of mind in association with spirit sublimation that allow one person to see through events and get new insights. Achieving the state of "Zuo Wang", a person can remain calm or unruffled so that he or she can cope with any situation (Allinson, 1989; Huang, 2016; Mitchell, 2010). It can illustrate nurses to go beyond the superstition or death taboo and value their experiences. This state of mind is consistent with the concept of "disinterested", which was proposed by the Japanese philosopher Kuki Shuzo (1888–1941). This concept describes a person who experiences difficult situations and suffering based on perspectives of fate, resignation or acceptance of the facts, permitting detachment from worldly concerns. "Disinterested" is one of the structures of "I-KI", which is a central idea in Kuki Shuzo's philosophy. I-KI is a phenomenon of consciousness that arises from the world of suffering in which we are barely able to remain afloat. Resignation, or disinterest, represents a state of mind that is free from obstacles and that has removed itself from any ego-centred attachment of reality (Nara, 2004). When nurses are enlightened by their own experiences, they can direct actions of care by minds instead of routines or SOPs. This mind-set allows nurses to be truly present with their patients without being completely overwhelmed by the painful complexities before them. The nurses in our study realized that doing nothing is still doing something. The nurses adjusted their care actions, set their professional desires aside, and waited for the chance to provide care because nurses who are social and educated know that doing whatever is needed is part of caring and being a "good nurse" (Dahlke and Stahlke Wall, 2016). Additionally, nurses committed to staying in EOL care because they were grateful for their daily experiences. As a result, they maintained passion for nursing.

There are a number of limitations in our analysis, although these can help inform and strengthen future studies on this topic. For example, all participants were female, so there were no male nurses' experiences available for comparison. The reason why no male nurses were included in this study is because few male nurses worked in the wards that were used for this study. Even though only a few male nurses work in these wards, it is still important to understand the EOL care experience from male nurses' perspectives. Additionally, all participants were oncology or hospice nurses. Therefore, other nurses who have EOL care experience in different settings were not represented. This research did not receive any specific grants from funding agencies in the public, commercial, or not-for-profit sectors.

5. Conclusions

In an empirical, scientific and rational medical context, providing EOL care is challenging for nurses. The results show that experiences from EOL care can be recognized as an opportunity for nurses to encounter their inner selves and help them establish authenticity. This process empowers nurses to define themselves and encourages nurses to transform their suffering and divert their minds. Additionally, this process nurtures their passion for care because of what they have experienced directs them to provide care from patients' perspectives. Except that, our findings suggest setting a nurse reflective group and providing related EOL care training for nurses is important. This study also provides a new understanding of EOL nurses' experiences and indicates that this line of work should be recognized as a privilege.

Conflict of interest statement

Neither of the authors, Hsien-Hsien Chiang or Ying-Chun Liu, declares any conflict of interest.

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